Hy-Vee health
INFUSION CARE

KRYSTEXXA (PEGLOTICASE)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ______________________ **DOB:** ____________ **Phone:** ____________

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** ____________

Medical Information

Diagnosis: Chronic gouty arthropathy w/tophus (tophi)
Chronic arthopathy w/o mention of tophus (tophi)
Other: ____________

ICD-10 Code: ____________

Patient Weight: ________ lbs. **Allergies:** ____________

Therapy Order

Krystexxa Dose: 8 mg IV in 250 mL of NS IV over 120 minutes *Patient will be observed 1 hour post infusion.

Frequency: Every 2 weeks

Refills: 1 year Other: ____________

If you would like Hy-Vee Health to dispense the methotrexate, please check appropriate box:
Methotrexate 15 mg PO weekly x1 year (to begin 4 weeks prior to Krystexxa)

Protocol premedication orders: Solu-Medrol 125 mg IV, Benadryl 25 mg PO/IV
**Patient advised to take antihistamine day before infusion.*

Lab Orders: Serum uric acid 24-72 hours prior to infusion
G6PD serum level (required prior to first dose)
Other lab orders: ____________

Labs: Required labs to be drawn by Infusion Center Referring Provider

Other orders: ____________

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: ____________ **Signature:** ____________ **Date:** ____________

Provider NPI: ____________ **Phone:** ____________ **Fax:** ____________ **Contact Person:** ____________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ____________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other ____________

HY-VEEHEALTHINFUSION.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

© Hy-Vee Health 2023

Hy-Vee health INFUSION CARE

COMPREHENSIVE SUPPORT FOR KRYSTEXXA (PEGLOTICASE) THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's medication list

Krystexxa Service Request form

Supporting clinical notes (H&P) to support primary diagnosis

Product information suggests the co-administration of weekly oral methotrexate 15 mg and folic acid or folinic acid supplementation. Krystexxa alone may be used in patients where methotrexate is contraindicated or not clinically appropriate. If co-administering with methotrexate, start weekly methotrexate and folic or folinic acid supplementation at least 4 weeks prior to initiating and throughout treatment with Krystexxa.

Will the patient co-administer methotrexate or other immunomodulation therapy? Yes No

If yes, which drug? ______________________

Documentation of frequency and date of flares in the last 18 months (either attach or document here):

____

Has the patient tried and failed Allopurinol/Uloric, Colchicine or Probenecid? Yes No

If yes, which drug(s)? ______________________

Labs attached, including:

Baseline serum uric acid **(required)**

G6PD serum level **(required)**

It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa

Other medical necessity: ______________________

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

HY-VEEHEALTHINFUSION.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

© Hy-Vee Health 2023