KRYSTEXXA
(pegloticase)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

• Has patient experienced at least 2 gout flares in previous 18 months? ☐ Y ☐ N
• Has patient stopped taking oral urate-lowering therapy? ☐ Y ☐ N
• Serum Uric Acid Level: _____ Date Drawn: _____
• G6PD Results: _____ Date Drawn: _____ - OR- G6PD to be drawn by Flourish ☐

PRIMARY DIAGNOSIS

☐ M1A.9xx0 Chronic gout, unspecified, without tophi
☐ M1A.9xx1 Chronic gout, unspecified, with tophi
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS (30 minutes prior to each infusion)

*Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Krystexxa 8mg IV every 2 weeks
☐ Other: _____

First Dose: ☐ Y ☐ N
☑ Refill x12 months unless otherwise noted: _____

SUPPORTIVE THERAPIES

Immunomodulators to be prescribed & managed by:
☐ Infusion Clinic ☐ Referring Provider

PRN Gout flare treatment:
☐ Colchine 0.6mg PO BID PRN gout flares
☐ Medrol Dosepak PRN gout flares
☐ Naproxen 500mg PO BID PRN gout flares

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date