



866 413-3156 toll free phone
 877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
 www.REPharmacy.com

**Krystexxa (Pegloticase) IV infusion for Gout
 Prescription Referral Form**

Send your RX to: (Select Location - optional)

Date Medication Needed: _____ Injection training by pharmacy?

Ship to: Patient's Home Prescriber's Office Pick-up (store location): _____

Location of administration: Doctor's Office Home Infusion Center

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical))

Patient Name: _____ Birth Date: _____ Gender: Male Female

Height: _____ Weight: _____ lbs. kg.

SS#: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ ZIP: _____

Insurance Info: _____ Policy Number: _____

2. PRESCRIBER INFORMATION

Provider Name: _____ DEA#: _____ NPI#: _____ TAX ID#: _____

Address: _____ Phone: _____ Fax: _____

City, State, ZIP: _____ Key Contact: _____ Phone #: _____

Specialty of Physician: Nephrologist Rheumatologist Podiatrist Other: _____

3. CLINICAL INFORMATION

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Indication: Chronic Gout uncontrolled with conventional therapy

Number of Gout Flare per year: _____

Initial G6PD Screened: Yes No

Uric acid level at baseline: _____ mg/dl

Uric acid level prior to infusion: _____ mg/d

Past/Current Medical History (select all that apply)

CHF BP Controlled Uncontrolled

Pregnant

Breast feeding

Anaphylactic reaction to previous IV therapy

Tophus

Joints affected: _____

3. CLINICAL INFORMATION (CONT.)

Previous Prophylactic or Treatment Drug Class Prescribed -

Drug Name:

Uloric (Febuxostat) Dose: _____ Duration: _____

Colcrys (Colchicine) Dose: _____ Duration: _____

Zyloprim (Allopurinol) Dose: _____ Duration: _____

Other drugs: _____

Outcomes: Not effective Contraindicated Intolerant Failed Suboptimal

Uncontrolled serum Uric acid level Other outcomes: _____

4. PRESCRIPTION INFORMATION

Dosing Administration (for **Krystexxa** vial)

Strength: 8mg/ml SDV

Dose: 8mg IV over 120mins every 2 weeks #of vials: _____ Other: _____

Supplies: Yes No

250 ml 0.9% Normal Saline Bag

250 ml 0.45% Normal Saline Bag (half Normal Saline) Other: _____

Number of Refills: _____

Premedication (SELECT ALL THAT APPLY)

IV CORTICOSTEROIDS (30-60 mins prior to infusion)

- 40mg IV Methylprednisolone
- 80mg IV Methylprednisolone
- 100mg IV Hydrocortisone
- 200mg IV Hydrocortisone
- Other: _____
- Number of vials: _____

ANTIHISTAMINE (30-60 mins prior to infusion)

- 60mg Allegra (Fexofenadine)
- 50mg Benadryl (Diphenhydramine)
 - Oral IV
- Other: _____

ORAL ANALGESIC

- 1000mg Tylenol (Acetaminophen)
 - 1 hour prior to infusion
- Other: _____

5. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature

Date

6. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written

Date

Substitution Permissible

Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

#of Prescriptions
