866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.**RE**Pharmacy.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: ______________________________________

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3. CLINICAL INFORMATION (CONT.)

Previous Prophylactic or Treatment Drug Class Prescribed -

Drug Name:

Uloric (Febuxostat) Dose: __________ Duration: __________

Colcrys (Colchicine) Dose: __________ Duration: __________

Zyloprium (Allopurinol) Dose: __________ Duration: __________

Other drugs:____

Outcomes: ☐ Not effective ☐ Contraindicated ☐ Intolerant ☐ Failed ☐ Suboptimal

☐ Uncontrolled serum Uric acid level Other outcomes: ____

4. PRESCRIPTION INFORMATION

Dosing Administration

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

☐ 40mg IV Methylprednisolone
30-60 mins prior to infusion

☐ 80mg IV Methylprednisolone
30-60mins prior to infusion

☐ 100mg IV Hydrocortisone
30-60 mins prior to infusion

☐ 200mg IV Hydrocortisone
30-60 mins prior to infusion

☐ Other: ____________________

☐ Number of vials: ______

ANTIHISTAMINE

☐ 60mg Allegra (Fexofenadine)
30-60 mins prior to infusion

☐ 50mg Benadryl (Diphenhydramine)
30-60 mins prior to infusion

☐ Other: ____________________

ORAL ANALGESIC

☐ 1000mg Tylenol (Acetaminophen)
1 hour prior to infusion

☐ Other: ____________________

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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 Permissable ____________________ 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

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