Updated September 17, 2019

Checklist for Krystexxa (pegloticase) Referral

Required documentation for all initial referrals

Patient _____DOB_____ Date_____ □ New Start □ Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- ☐ Patient demographics (e.g. address, phone number, SSN, etc.)
- ☐ Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber's date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- ☐ Signed and completed Krystexxa Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- ☐ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Krystexxa.
- ☐ Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required G6PD results**
    - **Lab results within last 14 days:** CBC with diff, CMP (to include ANC, AST & ALT) and Uric Acid every two weeks. *Serum Uric Acid level approximately 24-48 hours prior to each infusion.*
- ☐ Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: _____
  - Phone Number: _____

Paperwork can be faxed or emailed to (404) 528-1852, argpriorauth@articularishealthcare.com

Arthritis & Rheumatology of GA
Prior Authorization Department will assist you with any questions at
(404) 255-5956 extension: 910

Arthritis & Rheumatology of GA services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Arthritis & Rheumatology of GA Use Only Existing Patient Yes___ No___ Physician _____

Patient _____DOB_____ Date_____

Indication:

□ M10.00 Gouty arthropathy, unspecified	□ M10.00 Acute gouty arthropathy, including acute gout and flare	□ Other _____

History:

- Has the patient had failure, intolerance, or contraindication to conventional therapy? □ Yes □ No
- If yes, please specify treatment/medication tried and outcomes:
  _____
- Has the patient stopped taking any oral urate-lowering therapy? □ Yes □ No
- Is the patient G6PD deficient? □ Yes □ No

Orders:

□ Standard Order Protocol:

- Obtain patient weight each visit
- Baseline vitals will be obtained prior to administration, hourly during infusion and the 1 hour post infusion observation period, and prior to discharge home. Vital signs will be obtained more frequently if patient's condition warrants it.
- Instruct patient/caregiver on medications, signs/symptoms of adverse reaction.
- Assess patient for response to therapy.
- Infuse over 120 minutes.
- **If infusion reaction occurs, slow or stop infusion, and initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
- Observe patient 60 minutes after completion of infusion for adverse reaction.
- Discharge instructions to include possible infusion side effects and follow-up appointment schedule.

Dose:

Standard Dose Protocol:

- Krystexxa 8mg infused in 250mL in Normal Saline over 2 hours.
- Orders to be completed every 2 weeks.

Other:

Serum Uric Acid level approximately 24-48 hours prior to each infusion – hold infusion if 2 consecutive levels are above 6mg/dl. If patient misses 2 doses (4 weeks) resuming treatment must be cleared by ordering physician or therapy discontinued.

Premedicate:

Per package insert, pre-medicate x 1 dose 30 minutes prior to each infusion with:

□ 1000 mg Acetaminophen PO □ 25mg Benadryl IV □ 125mg Solu-Medrol IV Other_____

Additional orders/comments:

_____

_____

Practice Name: _____

Physician Name: _____

Physician Signature: _____

Date: _____

NPI: _____

State License: _____

DEA #: _____

UPIN: _____