INTRAMED Plus
infusion services

KRYSTEXXA®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnsosis):

Primary Diagnosis: _____Chronic Gout ICD-10 Code: M1A.0_____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- G6PD Screening Results (Qualitative)
- Medication list including current gout pharmacologic plan

❑ Patient to discontinue urate-lowering therapies (e.g. allopurinol, febuxostat, etc.) on _____

Patient
Weight: _____ lbs.
Height:_____ in.

Infusion Center – Lab Orders: (Check order for Infusion Center to manage):

❑ Obtain serum uric acid level (sUA) 24-48 hours prior to each infusion

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KRYSTEXXA® (pegloticase) J Code: 2507

4. Drug Order:

Krystexxa 8 mg IV over 2 (two) hours via a pump

Frequency: Administer every 2 (two) weeks _____# Refills (ecommend 11 Refills)

Pre-Medication Orders:

Acetaminophen 650 mg PO, Diphenhydramine 25 mg PO, and methylprednisolone 125 mg IV
Administered 30 min prior to infusion *Adjust to patient's needs

❑ Other:_____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**