

Pegloticase (Krystexxa)

Provider Order Form rev. 05/22/2026

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Gouty arthropathy: _____
Other: _____ Description: _____

Does patient have a Nephrologist: No Yes (If Yes): Provider Name: _____

REQUIRED INFORMATION

G6PD Results _____
 Baseline uric acid level _____ & date _____

THERAPY ADMINISTRATION & DOSING

Krystexxa 8mg IV every 2 weeks with weekly oral methotrexate 15mg and daily folic acid 1mg¹
 Methotrexate contraindicated and patient is on Krystexxa Monotherapy 8mg IV every 2 weeks
 Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion

¹Begin weekly Methotrexate and Folic Acid 4 weeks prior to the start of Krystexxa infusions.

FREQUENCY (Choose one)

Every 2 weeks
 Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

All premedication administered 30mins prior to infusion
 Loratadine 10mg PO
 Tylenol 500mg PO
 Solumedrol 125mg IV
 Benadryl 25 mg / 50mg PO / IV (**must have per PI**)
 Other: _____

LABORATORY ORDERS

Obtain serum uric acid level prior to each infusion (or may use result obtained within 48 hrs prior to infusion).

NURSING

Hold infusion and notify provider for:

- Uric acid level greater than 6 mg/dL for 2 consecutive treatments (lab orders below).
- Patient has had more than 4 weeks between treatments (due to increased risk for adverse reaction).
- Patient reports continued use of uric acid lowering agents (allopurinol, febuxostat, probenecid, etc.)
- Hypertension (170/90 or symptomatic)

Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with colchicine, NSAIDs, steroids, Febuxostat, Allopurinol, Probenecid. flares in 12 months, Gouty arthritis, Tophus
Required Labs: G6PD, UA level, CRP/ESR

Provider Name (print) _____ Provider Signature _____ Date _____

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.