Krystexxa

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

Please include the following to expedite the order:
Most Recent progress note, Insurance Info, Demographics, Medication List, Krystexxa Patient Enrollment Forms, and Glucose-6-Phosphate dehydrogenase (G6PD), CBC, CMP, BMP, and Uric Acid

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: ☐ Chronic Gout ☐ M1A.00X0 ☐ M1A.00X1, ☐ M1A.9XX0 ☐ M1A.9XX1

Other Dx/ICD10: _____

PROVIDER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Recommended per PI to start weekly methotrexate and folic acid or folinic acid supplementation at least 4 weeks prior to initiating, and throughout treatment. Patient will need to go to lab 2 days before every appointment to do a uric acid level, please send orders to lab and have them fax a copy to 818-659-8990

PREMEDS

☐ Diphenhydramine	◯ 25mg ◯ 50mg	☐PO	☐IV	☐Other _____	☐ N/A
☐ Acetaminophen	◯ 325mg ◯ 500mg ◯ 650mg	PO		☐ Other _____	☐ N/A
☐ Fexofenadine	☐ 60mg	PO		☐ Other _____	☐ N/A
☐ Methylprednisolone	◯ 40mg ◯ 125mg		IV	☐ Other _____	☐ N/A

Krystexxa Dose:

Pegloticase (Krystexxa) 8mg IV in 250 mL 0.9% Sodium Chloride every 2 weeks ADMINISTER KRYSTEXXA OVER 2 HOURS. Patient will be monitored 1 hour post-infusion.

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Smart Choice Infusion is authorized to administer generic or biosimilar.

☐ Uric Acid Level, 2-3 days prior to each infusion ☐ Prior to first appointment ☐ Other Frequency: