REVITALIZE
INFUSION CENTER

Krystexxa®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Chronic Gout ICD-10 Code: M1A.0_____

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
- Relevant labs and tests including:
  - G6PD Screening Results
  - Baseline serum uric acid results (sUA)
- Medication List

  ☐ Patient to start PO methotrexate and folic acid on:_____

  ☐ Patient to DC urate-lowering therapies on:_____

Height: _____

Weight: _____

Krystexxa (pegloticase) Orders:

Administer 8 mg intravenously over 2 hours every two weeks for 12 months

Pre-Medication Orders: Acetaminophen 650 mg, Diphenhydramine 25 mg PO and Methylprednisolone 125 mg IV administered 30 minutes prior to infusion adjusted PRN for patient's needs

☐ Other:_____

Lab Orders: ☐ Serum uric acid (sUA) 24-48 hours prior to each infusion

☐ Other:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus