O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Krystexxa (Pegloticase)

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal
Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:		Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE		REQUIRED DOCUMENTATION
☐ Chronic gout with Tophus	ICD 10 Code: M1A.9xx1	☐ This signed order form by the provider
☐ Chronic gout without Tophus	ICD 10 Code: M1A.9XX0	☐ Patient demographics AND insurance information (copy of cards)
☐ Other: _____	ICD 10 Code: _____	☐ Clinical/Progress notes
		☐ Lab and Tests supporting primary diagnosis
		☐ G6PD Test Results

Has patient been on Methotrexate for at least 6 weeks? ☐ Yes ☐ No MTX Start Date:
Is patient off oral urate lowering treatment? ☐ Yes ☐ No

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ OSMS Krystexxa premed protocol: 1000mg Tylenol PO, 25mg Benadryl IV push, 62.5mg Solumedrol IV push
☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg
☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg
☐ Fexofenadine (Allegra) PO ☐ 180mg

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

Dosing	☐ Krystexxa 8mg IV every 2 weeks
Refills	☐ X6 months ☐ X1 year ☐ _____ doses

**Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.*

LAB ORDERS

Patient will need uric acid level drawn 48 hours prior to their infusion. Please indicate where the patient will be getting their labs done:
☐ OSMS ☐ Other Clinic Name/Location:

_____

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.