LUX INFUSION

# Treatment Enrollment Form

Toll Free Phone: 1-866-665-3244 | Toll Free Fax:1-844-461-3244 | Email: infusions@luxinfusion.com

## Patient Information

Patient Name: _____ SSN#: _____ Gender: ☐ Male ☐ Female

DOB: _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ E-mail Address: _____

Emergency/guardian Contact: _____ Emergency/guardian Phone: _____

## Insurance Information – Please attach front and back of patient's insurance cards

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: _____

Prescription Card: ☐ Yes ☐ No _____ ID#: _____

PCP Referral Required: ☐ Yes ☐ No PCP Name: _____

## Prescriber Information

Prescriber's Name: _____ Hospital/Group: _____

Street Address: _____ Office Phone: _____

City, State, Zip: _____ Office Fax: _____

E-mail Address: _____ Office Contact Person: _____

NPI#: _____ Tax ID#: _____ State License#: _____

## Prior Authorization Information – For us to complete PAs for you, please send the following:

- ○ Patient demographic page
- ○ Patient SSN
- ○ Most recent H&P
- ○ Most recent labs
- ○ Copy of any/all insurance cards on file, both medical and pharmacy

Confidentiality Statement: The information contained in the following document(s) is legally privileged and confidential information intended only for the use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any viewing, dissemination, distribution, or copy of the attached document(s) is strictly prohibited. If you have received and/or are viewing attached document(s) in error, please immediately notify the sender and arrange for the immediate return or destruction of the attached document(s).

©2026 LUX Infusion. All Rights Reserved

Revised: March 2026

## Patient Information

Patient Name: _____ DOB: _____

# Krystexxa

Infusion Order Form

## Clinical Information

Primary ICD-10 Code: _____ Weight: _____ (kg ◯ / lbs ◯) Height: _____ (cm ◯ / in ◯)

Patient previously treated for this condition: ☐ Yes ☐ No Patient currently on treatment: ☐ Yes ☐ No

Known Allergies: _____

All ICD-10 codes for any/all related diagnosis (if not listed in H&P): _____

## Pre-medication Information

- ✓ **Acetaminophen 325mg, can be repeated x1, not to exceed 650mg, PRN**
- ✓ **Diphenhydramine 25mg PO or IV, PRN**
- ☐ _____
- ✓ **Methylprednisolone 125mg IV, PRN**
- ✓ **Ondansetron 4mg IV, PRN**
- ☐ _____

## Medication Information

| Medication (Note: PFS is abbreviation for Prefilled Syringes) | Directions/Frequency — IV Access Type: ☐ Peripheral ☐ PICC ☐ Port |
|---|---|
| **Krystexxa (pegloticase)**<br>☐ 8mg IV every 2 weeks | ☐ **Treatment x 12 months unless otherwise indicated below**<br>☐ **Treatment length x _____ month(s) or _____ weeks, frequency at every _____ week(s) or _____ month(s)** |
| ☐ Infusion Center to manage Immunomodulation oral therapy | |

## Laboratory Orders

- ✓ **G6PD level** ✓ **Before first infusio**
- ✓ **Serum Uric Acid** ✓ **Before each infusion**
- ✓ **Mycophenolate start date:** _____

- ☐ **CBC** ☐ **Before each infusion** ☐ **Frequency:** _____
- ☐ **CMP** ☐ **Before each infusion** ☐ **Frequency:** _____
- ☐ **CRP** ☐ **Before each infusion** ☐ **Frequency:** _____
- ☐ **Other:** _____

## Notes

- ✓ **Monitor Serum Uric Acid Level preferred 48 hours prior to each infusion – hold infusion if 2 consecutive levels are above > 6 mg/dL. If patient misses 2 doses (4 weeks) of therapy, then the referring physician must give written clearance to resume therapy or treatment will be discontinued**
- ✓ **Monitor patient for hypersensitivity reaction for a period of 60 minutes following infusion.**
- ✓ **In event of infusion reaction, follow Adverse Reaction Protocols for treatment.**
- ☐ **Infusion reaction special orders:** _____

## Prescriber Information

Prescriber Name: _____ Prescriber Phone: _____

By signing below, I certify that the above therapy is medically necessary, and I authorize treatment.

_____ _____

Substitution allowed Dispense as written

Date: _____ Date: _____

**Confidentiality Statement:** The information contained in the following document(s) is legally privileged and confidential information intended only for the use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any viewing, dissemination, distribution, or copy of the attached document(s) is strictly prohibited. If you have received and/or are viewing attached document(s) in error, please immediately notify the sender and arrange for the immediate return or destruction of the attached document(s).

©2026 LUX Infusion. All Rights Reserved

Revised: March 2026