NORTHWEST Kidney Centers

# Pruritus Assessment - Difelikefalin Request

Patient Name: ______________________________________ DOB: ______________

Does your patient have a diagnosis of Uremic Pruritus? (ensure this is documented in NKC EMR) ☐YES ☐NO (**ICD10 L29.9**)

Has your patient received therapy for uremic pruritus? ☐YES ☐NO

If YES, list therapies tried or currently taking (e.g. emollients, gabapentinoids, UV Rx, other anti-pruritics)

☐ Emollients Improved Symptoms ☐YES ☐NO

☐ Gabapentinoids Improved Symptoms ☐YES ☐NO

☐ UV therapy Improved Symptoms ☐YES ☐NO

☐ Other _____________ Improved Symptoms ☐YES ☐NO

Itch – Description: location, time (e.g. only at dialysis), rash associated

________________________________________________________________________

________________________________________________________________________

Adequate dialysis for last 2 months: ☐YES ☐NO

| **Worst Itching Over the Past 24 Hours** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Please indicate the worst itching you experienced over the past 24 hours | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| No itching | | | | | | | | | | Worst itching |
| Mild | | | | Moderate | | | Severe | | | |

Score for your patient at minimum on 2 different occasions, optimally more than 24 hours apart. Document dates.

#1 Score: ___________ Date: ____________________

#2 Score: ___________ Date: ____________________

Current opioid use: ☐YES ☐NO; if YES, what is Rx? _________________________

Does patient have allergy to opioids? ☐YES ☐NO

Physician signature: ______________________________ Date: ______________

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**Fax to Pharmacy 206-343-4884** CMO Approval required: ☐YES ☐NO