Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Krystexxa (pegloticase) Infusion Orders

Required Information:

- ☐ Signed order from prescribing provider
- ☐ Patient demographics including insurance information
- ☐ Supporting clinical documentation: Visit notes, diagnostic results including: **baseline Uric Acid Result >6.0 mg/dl, G6PD Screening**

Primary Diagnosis:

- ☐ Chronic Gouty Arthropathy w/ tophus(ICD-10 :_____)
- ☐ Chronic Arthropathy w/o mention of tophus(IDC-10:_____)
- ☐ Other:_____(ICD-10:_____)

KRYSTEXXA ORDERS

☐ Krystexxa 8mg IV over 2 hours followed by mandatory 1 hour observation period every 2 weeks

☐ Other:_____

Date of Last Krystexxa:_____

Administered per manufacturer guidelines

PRE-MEDICATIONS

☐ PO Tylenol _____mg

☐ PO Cetirizine _____mg

☐ IV Solu-medrol _____mg

☐ PO Loratadine _____mg

☐ PO ☐ IV Diphenhydramine _____mg

☐ PO ☐ IV Other:_____ _____mg

LABS

☐ CBC ☐ ESR ☐ Uric Acid

☐ CMP ☐ TB Quantiferon Gold ☐ Other:_____

☐ CRP ☐ Hep B Core/Surface AG ☐ Other:_____

Frequency:

- ☐ Every Visit
- ☐ Every Other Visit
- ☐ One time only
- ☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**