

**KRYSTEXXA (PEGLOTICASE)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress notes, labs, tests supporting primary diagnosis
- Baseline Uric Acid < 6.0 mg/dl

***Patient must have Uric Acid level drawn 24-72 hours prior to infusion**

***Patient must have Glucose-6-phosphate dehydrogenase (G6PD) deficiency screening prior to initiating therapy**

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Chronic Gouty Arthropathy w/tophus (tophi) (ICD-10 Code: _____)
- Chronic Gouty Arthropathy w/o mention of tophus (tophi) (ICD-10 Code: _____)

Krytexxa Orders
<input type="checkbox"/> Krystexxa (pegloticase) 8mg IV in 250ml of NS IV over 120 minutes *Patient will be observed 1 hr post infusion
<input type="checkbox"/> Frequency: Every 2 weeks
Protocol Pre-Medication Orders:
<input type="checkbox"/> Solu-Medrol 125mg IV
<input type="checkbox"/> Antihistamine 25mg ____PO OR ____ IV *Patient advised to take antihistamine day before infusion

Additional Instructions:

Physician Name:	Phone:	Fax:
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Physician Signature:	Date:
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