



Nucara Pharmacy Nucara Infusion Center
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 Austin, TX 78757 Austin, TX 78757
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 Fax: 512-524-1801 Fax: 512-524-1801

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

Other: _____

Date of Last Krystexxa: _____

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____mg

PO Cetirizine _____mg

IV Solu-medrol _____mg

Loratadine _____mg

PO

PO IV Diphenhydramine _____mg

PO IV Other: _____mg

LABS

CBC

ESR

Uric Acid

Frequency:

Every Visit

CMP

TB Quantiferon Gold

Other: _____

Every Other Visit

CRP

Hep B Core/Surface AG

Other: _____

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: