



### Krystexxa (Pegloticase) Infusion Order Form

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F

Allergies: \_\_\_\_\_

New Treatment     Continuing Treatment    Last Treatment Date: \_\_\_\_\_    Next Due Date: \_\_\_\_\_

**Diagnosis and ICD 10 Code (Required)**

Chronic Gout with Tophus    ICD 10 Code: M1A.9xx1     Chronic Gout without Tophus    ICD 10 Code: M1A.9xx0

**Required Labs**

Glucose-6-phosphate Dehydrogenase Status: \_\_\_\_\_

Uric Acid Results (within 48 hours of infusion) \_\_\_\_\_

Most recent CBC & CMP (attach results)

**Pre-Medication Orders**

Acetaminophen (Tylenol)     500mg     650mg     1000mg     PO

Diphenhydramine (Benadryl)     25mg     50mg     PO     IV

Methylprednisolone (Solu-Medrol)     125mg     IV

Ondansetron (Zofran)     4mg     8mg     PO     IV

Other: \_\_\_\_\_    Route: \_\_\_\_\_

Dose: \_\_\_\_\_    Frequency: \_\_\_\_\_

**Nursing**

Provide nursing care per Smart Infusion Nursing Procedures, including reaction management and post-procedure observation.

**Special Instructions / Notes**

**Provider Information**

Provider Name: \_\_\_\_\_    Provider NPI: \_\_\_\_\_

Office Phone: \_\_\_\_\_    Office Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_    Date: \_\_\_\_\_

<b>Krystexxa Medication Order</b>
Patient Weight: _____ KG
<u>Dosage</u>
<input type="checkbox"/> 8mg IV
<u>Frequency</u>
<input type="checkbox"/> Every 2 weeks
<input type="checkbox"/> Other _____

<b>Required Documents</b>
<input type="checkbox"/> Patient Demographic Sheet
<input type="checkbox"/> H & P within the past 6 months
<input type="checkbox"/> Current Medication List
<input type="checkbox"/> Clinical & Progress Notes (including last infusion note)
<input type="checkbox"/> Copy of Insurance Card (Front/Back)

<b>Location</b>
<input type="checkbox"/> Eau Claire <input type="checkbox"/> Weston <input type="checkbox"/> Middleton