smartinfusion THERAPY SERVICES

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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

☐ Other: _____ ICD 10 Code: _____

Required Tests (within 12 months & attach results)

Baseline Uric Acid Level & Date: _____

Glucose-6-phosphate Dehydrogenase Status & Date: _____

Required Labs (within 3 months & attach results)

Uric Acid Results (within 48 hours of infusion) _____

CBC Results _____

CMP Results _____

CRP Results _____

Other: _____

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: _____

Krystexxa Medication Order

Patient Weight: _____ KG

Dosage

☐ 8mg IV

Frequency

☐ Every 2 weeks

☐ Other _____

Required Documents

☐ Patient Demographic Sheet

☐ H & P within the past 6 months

☐ Current Medication List

☐ Clinical and Progress Notes

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: _____