

Krystexxa (Pegloticase) Infusion Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA Allergies: _____

New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- Acetaminophen _____mg by PO
- Cetirizine _____mg by PO
- Diphenhydramine _____mg by PO/ IVP
- Solu-Medrol _____mg by PO/ IVP
- Solu-Cortef _____mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Uric Acid level drawn 24-72 hours prior to each infusion
- G6PD blood test
- X-rays of joint/bone destruction if available
- History of gout medication, ULT (must stop one week prior to starting Krystexxa)
- Patient must be on Methotrexate four weeks prior to starting Krystexxa
- Other: _____

Patient Height and Weight:

Patient Height (cm): _____ Patient Weight (kg): _____

Krystexxa Medication Order (Please select ONE):

- Dosing (Please choose one)
 - 8 mg/kg
 - Other: _____
- Frequency (Please choose one)
 - Every 2 weeks
 - Other: _____

Please be advised that a new Uric Acid level is required within 24-72 hours prior to each infusion. It is recommended that treatment be discontinued if levels increase to about 6mg/dL, particularly when 2 consecutive levels above 6mg/dL are observed.

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400