



Krystexxa (pegloticase) | Order Form

	ient Name:					
Address:		City:	State:	Zip:		
L.	For new patients, please submit with	form:				
	☑ Copy of insurance card					
	☑ Patient demographics					
	☑ History & physical					
	☑ Labs/records including G6PD deficienc	y screening (if indicated*) and ba	seline uric acid levels			
!.	Patient Information					
	☐ Male ☐ Female Height:	in/cm Weight:	lbs/kg Allergies: _			
	Is this the first dose? \square Yes \square No, date of	last infusion:	Line type: PIV	□PICC □Port □Other		
}.	Diagnosis and Clinical Information					
	Primary diagnosis information: \Box Gout	☐ Other:	ICD-10 (required):			
	there an immunomodulator prescribed? Yes No If yes, please indicate: Methotrexate Other					
	Is patient currently taking oral urate-lowe	ering agents? \square No \square Yes . Oral	urate-lowering agents should b	e discontinued prior to		
	Krystexxa					
	G6PD deficiency screening and/or testing	results:				
\square Patient evaluated by provider and is not at risk and will not be tested (or tested negative)						
\square Patient is at risk for G6PD deficiency, and test results are: \square Positive (contraindicated) \square Negative						
	Baseline serum uric acid level:mg/c	dL (Must be >6.0mg/dL to initiate	Krystexxa)			
	ange lab draws locally					
	Name of lab facility:	PI	none number for lab results:			
	 Please fax results to PromptCare at 8 	00-815-6808 as soon as available	!			
	 A single uric acid of >6.0mg/dL will re 	equire follow-up with provider, by	ut will not post-pone next infu	sion		

4. Prescription Information

Medication	⊠ Krystexxa (pegloticase)			
Dosing / Frequency	⊠ 8mg in 250mL sodium chloride 0.9% IV every 2 weeks			
Administration	 ✓ Prepare and infuse per manufacturer guidelines. Infuse over no less than 2 hours and observe patient for at least 1 hour following infusion ✓ May infuse in patient home unless otherwise noted: 			
Quantity / Refills	Dispense 2-week supply on all selected medications; Refill x 12 months unless otherwise specified: ———————————————————————————————————			

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5.

6.

7.

Additional Orders				
☑ RN to start peripheral IV or use existing C\		r catheter flushing per F	romptCare Policy and	Procedure
 ☑ Give standard premedications 30 minutes ☑ Solu-medrol 40 mg OR ☑ Acetaminophen 650mg PO ☑ Antihistamine: patient may take select from the following OTC prod ☐ Diphenhydramine 25mg PO ☐ Cetirizine 10mg PO ☐ Loratadine 10mg PO 	mg IV night prior AND mo	orning of infusion. If not ☐ Fexofenadine 60 mg (Allegra 12 Hour) PO ☐ Fexofenadine 180 mg (Allegra 24 Hour) PO		nt/pharmacist may
☐ Other:				
 ☑ RN to instruct patient to hydrate pre/post manufacturer dosing recommendations as it. ☑ RN to monitor patient for at least 1 hour product physician Adverse Reaction Orders Standard anaphylaxis kit to be dispensed and mg/mL vial), and NS IV. Additional orders: Prescriber Information 	needed to prevent/ post infusion and ed	treat post-infusion head lucate on possible side of ol: Epinephrine IM/SQ (1	lache. effects, allergic reaction mg/mL vial), diphenh	ons, and when to
Prescriber Name:				
Address:	Ci	ty:	State:	Zip:
Phone:	Fax:		License No.:	
DEA No.:	NPI:			
Physician Signature (Substitution Permitted)	Date	Physician Signature	Dispense as Written)	 Date

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