Intravene - Krystexxa Infusion Orders (rev 11/2018)

Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____Sex_____
Height _____ Weight _____
Allergies _____
Primary Insurance _____
Secondary Insurance _____

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone _____
Physician Fax _____
NPI# _____ DEA # _____
State License#_____

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DIAGNOSIS: (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

GOUT MEDICATIONS (Tried and Failed):

☐ Allopurinol
☐ Colchicine
☐ Febuxostat
☐ NSAID
☐ Prednisone
☐ Sulfinpyrazone
☐ Other:_____

CONTRAINDICATIONS: (Patients of African or Mediterranean ancestry should be screened)

Does the patient have G6PD deficiency? ☐ Yes ☐ No Date of Test:_____

Patient must be on medication 1 week prior to first treatment with NSAIDS and/or Colchicine for at least 6 months.

STANDARD ORDERS

Infuse Krystexxa (pegloticase) 8mg in NS 250ml over 2 hours every 2 weeks for 1 year. Infuse per Intravene protocol. Upon completion of Krystexxa infusion, infuse Normal Saline 20ml. Observe patient for one hour after infusion.

Premedications:
Methylprednisolone 125mg IV 30 minutes prior to infusion.
Diphenhydramine 25mg -50mg PO or IV 30 minutes prior to infusion.
Acetaminophen 650mg PO 30 minutes prior to infusion.

Anaphylactic meds available at the chairside:
Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD
Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD
Diphenhydramine 50mg vial. Administer 50 mg IV push upon order of MD

LAB ORDERS:
☐ Serum Uric Acid Level **PRIOR** to each infusion (If after 1st infusion level is greater than 6mg/dl, hold therapy until MD contacted)

VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____