Infusion Associates
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Krystexxa IV Infusion ORDERS
(Pegloticase)

Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

DX CODES: ***ICD-10*** : **_____, _____, _____**

Has G6PD status been verified? □ No □ Yes Date and result of screening:_____

LABS to be drawn within 5 days of receiving EVERY infusion (at an outside lab):

- □ **Uric Acid**
- □ **Other: _____**

Infusion will be held if uric acid is > 6 mg/dL

Pre- Medications *(recommended):*

Diphenhydramine PO	50mg	□Yes □ No
Hydrocortisone IV	200 mg	□Yes □ No
Acetaminophen PO	650mg	□Yes □ No

Krystexxa IV Dosage:

□ 8 mg IV q2weeks
Infuse over 2 hours

1 hour post infusion observation time

Rx Expiration Date: _____/_____/_____

Patient must be on a NSAID or colchicine for at least 1 week before initiation of Krystexxa and remain on it for at least 6 months

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____Office Fax Number: _____