Krystexxa Infusion Order

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:**

☐ Demographics ☐ Insurance Information ☐ Current Medications
☐ H & P Relevant to the Diagnosis ☐ Current Uric Level
☐ G6PD Lab Results ☐ Krystexxa Patient Enrollment Form

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___ - ____ Fax: (___) ___ - ____

Office Address: _____

Contact Person: _____

PRE-MEDICATIONS: (30 MINUTES BEFORE INFUSION)

Acetaminophen:	☐ PO		☐ 650 mg		☐ Pre-med	☐ PRN
Diphenhydramine:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Fexofenadine (Allegra):	☐ PO		☐ 60 mg		☐ Pre-med	☐ PRN
Solu-Medrol:		☐ IV	☐ 40mg		☐ Pre-med	☐ PRN
Normal Saline Bolus:		☐ IV	☐ 250mL	☐ 500mL	☐ Pre-med	☐ PRN

KRYSTEXXA (PEGLOTICASE) IV DOSAGE:

8mg in 250 mL 0.9% Sodium Chloride every 2 weeks

ADMINISTER KRYSTEXXA OVER 2 HOURS. Patient will be monitored 1 hour post-infusion.

Start Date of Infusion: ___/___/___ Duration: _____