


PEGLOTICASE (KRYSTEXXA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: **(833) 220-8700**

	Patient Name: _____	Date of Birth: _____		
	Address: _____			
	Phone: _____	Height: _____	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: _____

Clinical Information

Primary Diagnosis Description: Gout (chronic)	ICD-10 Code: _____
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Pegloticase (Krystexxa®) Prescription

Pegloticase (Krystexxa®) 8 mg/mL 2 mL SDV refill as directed x 1 year

Infuse 8 mg IV over at least 2 hours every two weeks.

Pharmacy to contact prescriber for serum uric acid levels ≥ 6 mg/dL for orders to hold infusion and repeat serum uric acid level.

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care policy – please complete Anaphylaxis Physician Order (FR-PC-036).

Medication Orders

Acetaminophen 1000 mg PO 30 min before infusion. Patient to supply.

OTC PO antihistamine of choice and dose: _____

Take PO the night prior to infusion and take dose again 30 min prior to infusion. Patient to supply.

Corticosteroid Pre-Medications: Select **ONE** of the following:

Solu-Cortef® 200 mg IV prior to infusion.

Methylprednisolone 80 mg IV prior to infusion.

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

Serum uric acid level drawn 1 to 2 days prior to each infusion following the initial infusion and PRN for serum uric acid levels ≥ 6 mg/dL

Other: _____

Skilled nurse to administer doses intravenously. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name: _____	Phone: _____	Fax: _____
Address: _____	NPI: _____	
City, State: _____	Zip: _____	Office Contact: _____

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