PEGLOTICASE (KRYSTEXXA®) PRESCRIBER ORDER FORM

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Gout (chronic) **ICD-10 Code:**

Date Methotrexate and Folic Acid Initiated:

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 greater than 6 mg/dL.

Ancillary Orders

Anaphylaxis Kit

Dosage:
- SUBQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit – Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x 1 PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Acetaminophen 1000 mg PO 30 min before infusion.

☐ OTC PO antihistamine of choice and dose: _____

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

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: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 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.
Contact prescriber for serum uric acid levels greater than 6mg/dL. Recommend to dose Krystexxa as scheduled if first elevated level AND patient has not experienced any infusion reactions previously). If second consecutive elevated level greater than 6mg/dL, contact prescriber and discontinue Krystexxa.

☐ 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:**

Fax completed form, insurance information, and clinical documentation to: 866-248-4918

