PEGLOTICASE (KRYSTEXXA®) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

