

<b>PEGLOTICASE (KRYSTEXXA®) PRESCRIBER ORDER FORM</b>				
Patient Name:		Date of Birth:		Gender:
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description: Gout (chronic)			ICD-10 Code:	
Allergies: <input type="checkbox"/> NKDA or (List):				
Date Methotrexate and Folic Acid Initiated:				
Pegloticase (Krystexxa®) Prescription				
<input type="checkbox"/> Pegloticase (Krystexxa®) 8 mg/mL SDV in 250mL normal saline IV at 125mL/hr every two weeks. Refill as directed x 1 year. <input type="checkbox"/> Pegloticase (Krystexxa®) 8 mg/50 mL RTU SDV IV at 25mL/hr via infusion pump every two weeks. Flush tubing post-infusion. Refill as directed x 1 year. Pharmacy to contact prescriber for serum uric acid levels greater than 6 mg/dL.				
Ancillary Orders				
<b>Anaphylaxis Kit</b> Dosage: <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> <li>▪ 0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li> </ul>				
<b>Medication Orders</b> <input type="checkbox"/> Acetaminophen 1000 mg PO 30 min before infusion. <input type="checkbox"/> 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.				
<b>Corticosteroid Pre-Medications:</b> <u>ONE</u> of the following <b>MUST</b> be selected unless contraindicated: <input type="checkbox"/> Hydrocortisone Sodium Succinate 200 mg IV prior to infusion. <input type="checkbox"/> Methylprednisolone Sodium Succinate 80 mg IV prior to infusion.				
<b>IV Flush Orders</b> <ul style="list-style-type: none"> <li>• <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.</li> <li>• <u>Implanted Port:</u> 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.</li> </ul>				
<b>Lab Orders</b> <input checked="" type="checkbox"/> Serum uric acid level drawn 1 to 2 days prior to each infusion following the initial infusion. <b>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.</b> <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
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: <b>713-983-4647</b>				
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