Intravene - Krystexxa Infusion Orders (rev 10/2018)
Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION	REFERRING PHYSICIAN INFORMATION
Name	Physician Name
Address	Physician Address
City	
State Zip code	Physician Phone
Home Phone #	Physician Fax
Work Phone #	NPI# DEA #
DOBSSNSex	State License#
Height Weight	
Allergies	
Primary Insurance	** Please fax copy of insurance cards**
•	
Secondary Insurance	and this form to (434)- 455-5531
<u>DIAGNOSIS: (ICD-10 required)</u>	
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CURRENT GOUT MEDICATIONS:	
(Patient must be on medication 1 week prior	or to first treatment)
☐ ↑ Allopurinol	to mist treatment)
□ ↑ Colchicine	
☐ † Febuxostat	
□ ↑ NSAID	
□ ↑ Prednisone	
□ ↑ Sulfinpyrazone	
□ ↑ Other:	_
CONTRAINDICATIONS: (Patients of Afri	ican or Mediterranean ancestry should be screened
Does the patient have G6PD deficiency? Yes Yes	NO Date of Test:
STANDARD ORDERS	
Infuse Krystexxa (pegloticase) 8mg in NS 250ml over	2 hours every 2 weeks for 1 year. Infuse per Intravene
- · · · · · · · · · · · · · · · · · · ·	se Normal Saline 20ml. Observe patient for one hour after
infusion.	
Premedications:	
Methylprednisolone 125mg IV 30 minutes prior to infus	sion .
Diphenhydramine 25mg -50mg PO or IV 30 minutes prior	
Acetaminophen 650mg PO 30 minutes prior to infusion.	
Anaphylactic meds available at the chairside:	
Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5ml)	
Hydrocortisone 100mg vial. Administer 100mg IV push	
Diphenhydramine 50mg vial. Administer 50 mg IV pus	sh upon order of MD
LAB ORDERS:	
	eter 1st infusion level is greater than 6mg/dl, hold therapy until
MD contacted)	1 Intusion 10 (01 to ground main onig/ut, note therapy until
VITAL SIGNS MONITORING PER INTRAVENE PR	OTOCOL
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Signature, prescribing MD	Date