



MEDICATION ORDERS-KRYSTEXXA (PEGLOTICASE)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Chronic gout with Tophus	ICD 10 Code: M1A.9xx1
<input type="checkbox"/> Chronic gout without Tophus	ICD 10 Code: M1A.9XX0

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Uric acid level	<input type="checkbox"/> G6PD test results
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
3)	

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Krystexxa 8mg IV every 2 weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____doses

MEDICATION ORDERS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to Krystexxa infusion	
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Krystexxa infusion	
<input type="checkbox"/> Methylprednisolone 40mg Slow IV Push prior to Krystexxa infusion	
<input type="checkbox"/> Other:	

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PRESCRIBER INFORMATION		
Prescriber Name:		
		Office
Office Phone:	Office Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: info@rosenursing.net
or call **887.797.4632 / 954.432.8290**

Fax completed form and all documentation to **844.246.3364**

All information contained in this form is strictly confidential and will become part of the patient's medical record.