(pegloticase)

KRYSTEXXA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Chronic Gout

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ _____
(other)

☐ Length of Need _____

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____
(other)

KRYSTEXXA ORDERS

DOSAGE/FREQUENCY

◯ 8mg IV every 2 weeks

PREMEDICATION PER PRESCRIBING INFORMATION

◯ Solu-medrol 125mg IV

◯ Diphenhydramine 25mg PO

◯ Refills: _____

PATIENT WEIGHT

_____ lbs.

_____ kg

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887