


# PEGLOTICASE (KRYSTEXXA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____		
	<b>Address:</b> _____			
	<b>Phone:</b> _____	<b>Height:</b> _____	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b> _____

## Clinical Information

<b>Primary Diagnosis Description:</b> Gout (chronic)	<b>ICD-10 Code:</b> _____
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**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:
- SQ 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.
  - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

### 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: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 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.

*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

<b>Prescriber Name:</b> _____	<b>Phone:</b> _____	<b>Fax:</b> _____
<b>Address:</b> _____	<b>NPI:</b> _____	
<b>City, State:</b> _____	<b>Zip:</b> _____	<b>Office Contact:</b> _____

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