Pegloticase (Krystexxa)

Optimum INFUSION

PATIENT INFORMATION

Referral Status: ◯ New Referral ◯ Updated Order ◯ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation

☑ Baseline Serum Uric Acid level and date (Please provide results):
_____

☑ Glucose-6-phosphate dehydrogenase (G6PD) results and date (Please provide results):
_____ _____

☑ Please indicate if patient is currently prescribed any immunomodulator therapy such as: methotrexate, mycophenolate, leflunomide, azathioprine, or cyclosporine:
_____

☑ Evidence supports the combination of Krystexxa and an immunomodulator in improving the patient's response to therapy; consider adding an immunomodulator if clinically appropriate.

RECOMMENDED PRE-MEDICATION ORDERS

The following pre-medications are recommended by the manufacturer as a standard premedication regimen.

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

SPECIAL INSTRUCTIONS

ADDITIONAL PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other: _____ ___
Dose: _____ Route: _____ ___
Frequency: _____ ___

LABORATORY ORDERS

☑ Uric acid ☑ at each dose
☐ CBC ☐ at each dose ☐ every _____ _____
☐ CMP ☐ at each dose ☐ every _____ _____
☐ CRP ☐ at each dose ☐ every _____ _____
☐ Other: _____ _____

THERAPY ADMINISTRATION

☑ **Pegloticase** (Krystexxa) intravenous infusion
- Dose: 8mg
- Route: ☑ intravenous
- Frequency: every 2 weeks
- Infuse over 120 minutes per manufacturer's guidelines

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Patient is required to stay for one-hour observation period
☐ Refills: ☐ Zero / ☐ for 6 months / ☐ for 12 months / ☐ Other:
_____ _____ ___
(if not indicated order will expire one year from date signed)

*Patients should be pre-medicated with antihistamines and corticosteroids. *Monitor serum uric acid levels prior to infusions. Consider ceasing treatment if levels increase above 6 mg/dL, especially if 2 consecutive levels above 6 mg/dL are observed. *Screen patients at risk for G6PD deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. Do not administer KRYSTEXXA to patients with G6PD deficiency. *Observation of patients for approximately an hour post-infusion should be considered.

Provider Name (Print) **Provider Signature** **Date**

SUBMIT ORDER FORM TO OPTIMUM INFUSION:
☐ **FAX:** 505-420-4848
☐ **EMAIL:** refer@optimuminfusion.com