Local Infusion

MYLOCALINFUSION.COM

KRYSTEXXA (PEGLOTICASE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Chronic Gout, ICD 10: M1A. _____

❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP

☑ Benadryl 25mg PO

❑ Famotidine 20mg IV

❑ Acetaminophen (Tylenol) 500mg PO

❑ Cetirizine (Zyrtec) 10mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Krystexxa	8 mg	IV	Every 2 weeks

LABS / SPECIAL INSTRUCTIONS