NORTH TEXAS INFUSION CENTERS

Krystexxa® (pegloticase) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information

2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____

Patient Name **DOB**

_____ _____ _____

Weight **Allergies** **Patient Phone**

Medical History (required)

Patient previously treated with Krystexxa? ◯ Yes ◯ No Dates:_____

G6PD Deficient ◯ Yes ◯ No Previous History of Gout Treatment_____

◯ **iagnosis (must include ICD-10 code)**

◯ Chronic Gouty Arthropathy w/out mention of tophus(tophi) _____

◯ Chronic Gouty Arthropathy with mention of tophus(tophi) _____

◯ Other _____

Prescription Orders: Krystexxa® (pegloticase)

Infuse Krystexxa 8 mg in NS 0.9% 250 ml IV over 2 hours Q 2 weeks x 6 months

**Labs must be drawn 2-3 days prior to infusion. If uric acid > 6mg/dl x 1, approval must be given by prescribing physician. If uric acid > 6 mg/dl x 2 consecutive draws, infusion will NOT be given.

Pre-Medications: ◯ Loratadine 10mg PO night before & morning of infusion

◯ Allegra 24hr (180mg) **OR** ◯ Allegra 12 hr (60mg) PO night before & morning of infusion

Prior to Infusion:

◯ Solu Cortef 200 mg IVP ◯ Acetaminophen 1000mg PO ◯ Solu Medrol 40mg IVP

_____

Physician Name **Phone** **Fax**

_____

Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.

Or visit us online at www.ntinfusioncenters.com