

KRYSTEXXA® (pegloticase)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____


Required Documentation

Patient Demographics and Insurance Card Medication List Recent labs including Glucose-6-phosphate dehydrogenase(G6PD) results
 Clinical/Progress Notes Supporting Dx Baseline Serum Uric Acid level



Primary Diagnosis

 ICD-10 Code (required): _____
 Chronic gout with Tophus Chronic gout without Tophus
 Other: _____

Pre-Medication

Per violet health protocol: Acetaminophen 650 mg PO, diphenhydramine 25 mg IV, Solu-medrol 125 mg IV 30 min prior to each infusion 
 Other: _____
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetrizine (Zyrtec) 10 mg PO

Therapy Administration

Krystexxa 8mg IV every 2 weeks
 Other: _____
 PI suggests co-administration of methotrexate and folic acid therapy if not contraindicated
 Immunomodulators to be prescribed and managed by Referring Provider
Refills:
 x 1 year Other: _____
 Order valid for one year unless otherwise stated
 RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____