(pegloticase)

KRYSTEXXA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Chronic Gout

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

KRYSTEXXA ORDERS

DOSAGE/FREQUENCY

◉ 8mg IV every 2 weeks

PREMEDICATION PER PRESCRIBING INFORMATION

○ Solu-medrol 125mg IV

○ Diphenhydramine 25mg PO

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

Please return by fax to: (806) 503-2200 or email to: referrals@icareama.com.