



INFUSE ONE

(Pegloticase)

# Krystexxa infusion orders

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Phone Number \_\_\_\_\_

M \_\_\_\_ F \_\_\_\_

**DIAGNOSIS** *Please provide ICD-10 code*

\_\_\_\_\_ Gout

\_\_\_\_\_ Other

**PRE-MEDICATIONS** (optional)

Acetaminophen 1000mg PO

Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO

Solu-Cortef 100mg IVP

Cetirizine 10mg PO

Diphenhydramine 25mg IVP

\_\_\_\_\_ (other)

\_\_\_\_\_ (other)

## Krystexxa (Pegloticase) ORDERS

**DOSAGE & FREQUENCY**

8mg IV once every 2 weeks

\_\_\_\_\_ Other

**Patient Weight**

\_\_\_\_\_ lbs

\_\_\_\_\_ kg

**NOTES:**

## ORDERING PROVIDER

Signature \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Provider \_\_\_\_\_ Date \_\_\_\_\_