

(pegloticase)

Date: _____

KRYSTEXXA infusion orders

Patient Name _____ DOB _____

Phone _____ J-Code J2507 M ☐ F ☐

NPI _____ Tax ID _____ ☐ Allergies _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS Please provide ICD-10 code

- ☐ _____ Chronic Gout
☐ _____ (other)

REFERRAL STATUS

- ☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

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
☐ Other _____

PATIENT WEIGHT

_____ lbs.
_____ kg

PREMEDICATION PER PRESCRIBING INFORMATION

- ☐ Solu-medrol 125mg IV
☐ Diphenhydramine 25mg PO
☐ Other _____

Total Dosages ☐ Refills _____

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____