COASTAL INFUSION SERVICES

1922 Highway 22 W, Suite A
Madisonville, LA 70447
Local: 985-792-9001
Toll-Free: 833-285-5500
Fax: 985-792-9004
Toll-Free: 833-235-1686

Krystexxa (pegloticase) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card
☒ Patient demographics
☒ History & physical
☒ Labs/records including G6PD deficiency screening (if indicated*) and baseline uric acid levels

2. Patient Information

☐ Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg Allergies: _____

Is this the first dose? ☐Yes ☐No, date of last infusion: _____ Line type: ☐ PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

Primary diagnosis information: ☐ Gout ☐ Other: _____ ICD-10 (required): _____ **Is there an immunomodulator prescribed?** ☐ Yes ☐ No **If yes, please indicate**: ☐ Methotrexate ☐ Other _____ **Is patient currently taking oral urate-lowering agents?** ☐ No ☐ Yes . Oral urate-lowering agents should be discontinued prior to Krystexxa

G6PD deficiency screening and/or testing results:

☐ Patient evaluated by provider and is **not** at risk and will **not** be tested (or tested negative)
☐ Patient is at risk for G6PD deficiency, and test results are: ☐ Positive (contraindicated) ☐ Negative

Baseline serum uric acid level: _____mg/dL (Must be >6.0mg/dL to initiate Krystexxa)

- Uric acid levels are required to be drawn 1 to 2 days prior to each infusion, **referring provider to arrange lab draws locally**
  Name of lab facility: _____ Phone number for lab results: _____
- Please fax results to Coastal Infusion Services at 985-792-9004 as soon as available
- A single uric acid of >6.0mg/dL will require follow-up with provider, but will not post-pone next infusion

4. Prescription Information

Medication	☒ **Krystexxa** (pegloticase)
Dosing / Frequency	☒ 8mg in 250mL sodium chloride 0.9% IV every 2 weeks
Administration	☒ Prepare and infuse per manufacturer guidelines. Infuse over no less than 2 hours and observe patient for at least 1 hour following infusion ☒ May infuse in patient home unless otherwise noted: _____
Quantity / Refills	Dispense 2-week supply on all selected medications; Refill x 12 months unless otherwise specified: _____ Dispense all medical supplies necessary for infusion

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5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services Policy and Procedure

☒ **Give standard premedications 30 minutes prior to infusion:**

☒ Solu-medrol 40 mg **OR** _____ mg IV

☒ Acetaminophen 650mg PO

☒ Antihistamine: patient may take night prior AND morning of infusion. If nothing is checked, patient/pharmacist may select from the following OTC products:

☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Loratadine 10mg PO
☐ Fexofenadine 60 mg (Allegra 12 Hour) PO
☐ Fexofenadine 180 mg (Allegra 24 Hour) PO

☐ Other: _____

☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

☒ RN to monitor patient for at least 1 hour post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ License No.: _____

DEA No.: _____ NPI: _____

_____ _____ _____ _____

Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date