Comanche County Memorial Hospital

Outpatient Infusion Center
Krystexxa Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender ☐ M ☐ F

Patient Address: Email: Insurance:

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs

☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ M1A.00X0 Idiopathic Chronic Gout, Unspecified Site, without Tophus

☐ M1A.00X1 Idiopathic Chronic Gout, Unspecified Site, with Tophus

☐ M1A.09X0 Idiopathic Chronic Gout, Multiple Sites, without Tophus

☐ M1A.09X1 Idiopathic Chronic Gout, Multiple Sites, with Tophus

☐ Other DX: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation

☐ Patient Weight: _____ lbs/_____ kg ☐ Patient Height: _____ in/ _____ cm

☐ Allergies: _____

☐ Therapies Tried and Failed: _____

☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____

☐ Does the patient have venous access? ◯ Yes or ◯ No If yes, What type? _____

If no, Initiate IV access

Lab Orders

☐ CBC w/out diff ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB

☐ Quantiferon Gold HIV G6PD Uric Acid

☐ Other: _____

Lab Orders to be done by

☐ Infusion Services

☐ Referring Provider

Pre-Medications

☐ Benadryl _____ mg PO IVP once 30 min prior to infusion

☐ Acetaminophen _____ mg PO IVPB once 30 min prior to infusion

☐ Methylprednisolone _____ mg PO IVP once 30 min prior to infusion

☐ PICC/ Midline/ CAD dressing to be changed every 7 days.

Misc Orders

☐ Krystexxa ☐ Dose: 8mg

Flushes

☐ Frequency: every 2 weeks

Misc Orders

☐ _____

☐ _____

Flushes

☐ 10mL NS Flush Syringe PRN

☐ Heparin 500units/5mL Flush Syringe PRN

☐ 50ml NS Bag PRN

☐ 250ml NS Bag PRN

Standing Orders for Adverse Reactions

☐ Stop infusion and initiate NS bolus

☐ Notify Supervising physician and ordering provider

☐ Solu-Cortef 100mg SIVP signs of adverse reaction

☐ Benadryl 25mg SIVP for hives or bronchial inflammation

☐ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis

☐ Oxygen 2-5L nasal cannula

☐ Albuterol 2.5mg inhaled PRN for chest tightness

☐ Other: _____

Prescriber Information

Physician Name: _____ Office Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____ _____

Physician's Signature Date Time