



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

