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 patient demographics
- ☐ Fax clinical/progress notes
- ☐ Fax current medication list
- ☐ Fax labs
- ☐ 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 ________