



Preferred Clinic Location

- ☐ **Harbor Health Park Bend Clinic**
 2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
 P: (855) 481-8375
 F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: _____ Patient Name: _____ DOB: _____
 ICD-10 code (required): _____ ICD-10 description: _____
☐ NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
 Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Provider Information

Referral Coordinator Name: _____ Referral Coordinator Email: _____
 Ordering Provider: _____ Provider NPI: _____
 Referring Practice Name: _____ Phone: _____ Fax: _____
 Practice Address: _____ City: _____ State: _____ Zip Code: _____

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Perform serum uric acid test prior to each infusion
- Screen patients at risk for G6PD deficiency prior to starting therapy
- Patient had chronic gout and is an adult patient who has failed to normalize serum or has shown inadequate response to conventional therapy

Orders

NURSING

- ☒ Nursing care per [Harbor Health Nursing Procedures](#) and [Harbor Health Adverse Reaction Management Protocol](#).
☒ Verify discontinuation of any oral urate-lowering medication throughout duration of therapy.
☒ Verify Baseline Serum Uric Acid level and date prior to each infusion (Please provide results): _____
☒ Glucose-6-phosphate dehydrogenase (G6PD) results and date (Please provide results): _____
☒ Please indicate if patient is currently prescribed any immunomodulator therapy such as: methotrexate, mycophenolate, leflunomide, azathioprine, or cyclosporine (write name of immunomodulator on line below): _____
☒ Verify use of folic acid supplementation

**Evidence supports the combination of Krystexxa and an immunomodulator in improving the patient's response to therapy; consider adding an immunomodulator if clinically appropriate.*

LABORATORY

- ☐ Uric acid ☐ at each dose
☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION

The following pre-medications are recommended by the manufacturer as a standard premedication regimen.

- ☒ Administer pre-medications at least 30 minutes prior to start of infusion
☒ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☒ methylprednisolone (Solu-Medrol) ☐ 40mg / ☒ 125mg IV

ADDITIONAL PRE-MEDICATION

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

Continued on page 2

Krystexxa (Pegloticase)

Infusion Order Form – Page 2 of 2



Date: _____ Patient Name: _____ DOB: _____

Orders, cont.

THERAPY

- ☒ **Pegloticase** (Krystexxa) in 250ml 0.9% sodium chloride, intravenous infusion over 120 minutes
 - Dose: 8mg
 - Route: ☒ Intravenous
 - Frequency: ☐ every 2 weeks / ☐ other _____
 - Infuse over no less than 120 minutes
- ☒ Flush with 0.9% sodium chloride at infusion completion
- ☒ Patient is required to stay for 60-minute observation

**Patients should be pre-medicated with antihistamines and corticosteroids. *Monitor serum uric acid levels prior to each infusion. Consider ceasing treatment if levels increase above 6 mg/dL, especially if 2 consecutive levels above 6 mg/dL are observed. *Screen patients at risk for G6PD deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. Do not administer KRYSTEXXA to patients with G6PD deficiency.*

Special Instructions

NOTES:

Provider Name (Print): _____ Provider Signature: _____ Date: _____