

# PEGLOTICASE (KRYSTEXXA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: **(855) 647-2884**

**YOUR**  
**INTELLIGENT**  
**HEALTH**  
**COMPANY.**

**UBACARE**

Patient Name:

Date of Birth:

Address:

Phone:

Height:

inches  cm

Weight:

lbs  kg

## Clinical Information

Primary Diagnosis Description: Gout (chronic)

ICD-10 Code:

## Pegloticase (Krystexxa®) Prescription

**Pegloticase (Krystexxa®) 8 mg/mL 2 mL SDV refill as directed x 1 year**

Infuse 8 mg IV over at least 2 hours every two weeks.

Pharmacy to contact prescriber for serum uric acid levels  $\geq 6$  mg/dL for orders to hold infusion and repeat serum uric acid level.

## Ancillary Orders

### Anaphylaxis Kit

➔ Required per Option Care policy – please complete Anaphylaxis Physician Order (FR-PC-036).

### Medication Orders

Acetaminophen 1000 mg PO 30 min before infusion. Patient to supply.

OTC PO antihistamine of choice and dose: \_\_\_\_\_

Take PO the night prior to infusion and take dose again 30 min prior to infusion. Patient to supply.

**Corticosteroid Pre-Medications:** Select **ONE** of the following:

Solu-Cortef® 200 mg IV prior to infusion.

Methylprednisolone 80 mg IV prior to infusion.

Other: \_\_\_\_\_

### IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

### Lab Orders

Serum uric acid level drawn 1 to 2 days prior to each infusion following the initial infusion and PRN for serum uric acid levels  $\geq 6$  mg/dL

Other: \_\_\_\_\_

Skilled nurse to administer doses intravenously. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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