

Pegloticase (Krystexxa®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Date Methotrexate and Folic Acid Initiated: _____

Pegloticase (Krystexxa®) Prescription

Pegloticase (Krystexxa®) 8 mg/ml 2 ml Single-dose vial (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 greater than 6 mg/dl.

Ancillary Orders

Anaphylaxis Orders

- Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

- Acetaminophen 1000 mg PO 30 min before infusion.

- OTC PO antihistamine of choice and dose:

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

Corticosteroid Pre-Medications: Select ONE of the following:

- Solu-Cortef® 100 mg IV prior to infusion.

- Methylprednisolone 80 mg IV prior to infusion.

- Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

- Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders

- Serum uric acid level drawn 1 to 2 days prior to each infusion following the initial infusion.

Contact prescriber for serum uric acid levels greater than 6mg/dL. Recommend to dose Krystexxa as scheduled if first serum uric acid level is elevated AND patient has not experienced any infusion reactions previously. If second consecutive serum uric acid level is elevated greater than 6mg/dL, contact prescriber and discontinue Krystexxa.

- Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.

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 _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
N86 W12999 Nightingale Way

Menomonee Falls, WI 53051

262-532-5040