NATIONAL INFUSION CENTER ASSOCIATION

Patient Name:

DOB:

PEGLOTICASE (KRYSTEXXA®) INFUSION ORDERS

Diagnosis:

☐ M1A.9XX0 chronic gout, **with** tophi

☐ M1A.9XX1 chronic gout, **without** tophi

☐ Other: _____
(ICD-10 code and description)

Pre-treatment requirements have been met (documentation must be attached):

☐ Negative G6PD deficiency screening [Krystexxa contraindicated in setting of G6PD deficiency]

☐ Baseline uric acid level: _____ Date: _____

Immunomodulator Co-Therapy*

☐ Methotrexate 15 mg PO weekly with folic acid supplementation

☐ Other:

☐ N/A; Krystexxa monotherapy

Date immunomodulator started:

_____/_____/_____

*Shown to improve efficacy and reduce immunogenicity when initiated at least 4 weeks prior to initiating Krystexxa.

Pre-infusion Orders:

☑ Due to increased risk of anaphylaxis, hold infusion pending provider notification if:
- Uric acid level greater than 6 mg/dL; or,
- Patient reports ongoing use of urate-lowering agents (e.g., allopurinol, febuxostat, probenecid);

☑ Obtain vital signs at baseline and monitor every least every 30 minutes until infusion complete.

☑ If infusion-related reaction occurs, stop infusion, monitor patient and treat per orders/protocol as clinically indicated.

Lab Orders: ☑ Obtain serum uric acid level 24-48 hrs prior to each infusion.

Pre-medications: (Prescriber must select *one* option within each set of brackets for each medication selected):

☐ acetaminophen	[☐ 500 mg	☐ 650 mg	☐ 1000 mg]	PO	once	[☐ 30 ☐ 60] min prior to infusion
☐ methylprednisolone	[☐ 40 mg	☐ 125 mg	☐ _____ mg]	IVP	once	[☐ 30 ☐ 60] min prior to infusion
☐ hydrocortisone	[☐ 100 mg	☐ 200 mg	☐ _____ mg]	IVP	once	[☐ 30 ☐ 60] min prior to infusion
☐ cetirizine	[☐ 10 mg	--	☐ _____ mg]	[☐ IVP ☐ PO]	once	[☐ 30 ☐ 60] min prior to infusion
☐ diphenhydramine	[☐ 25 mg	☐ 50 mg	☐ _____ mg]	[☐ IVP ☐ PO]	once	[☐ 30 ☐ 60] min prior to infusion
☐ fexofenadine	[☐ 180 mg	--	☐ _____ mg]	PO	once	[☐ 30 ☐ 60] min prior to infusion
☐ loratadine	[☐ 10 mg	--	☐ _____ mg]	PO	once	[☐ 30 ☐ 60] min prior to infusion

Medication: ☑ Administer **Krystexxa 8 mg** in 250 ml 0.9% **sodium chloride** intravenously over at least **120 minutes**.

Frequency: ☐ Every 2 weeks

Post-Infusion Orders:

☑ Monitor patient for **60 minutes** following infusion to assess for hypersensitivity/adverse reaction.

☑ Educate patient/caregiver that flares may occur during the first six months of therapy and encourage adherence to prophylactic treatment (e.g., colchicine or NSAID) as prescribed.

☑ Fax treatment notes to provider at number below

Prescriber name (print): _____ Fax: _____

Prescriber signature: _____ Date: _____

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