Gabrail Cancer Center

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Phone 330-492-3345 Fax 330-491-9758

KRYSTEXXA pegloticase

Order Form

Patient Information

Patient Name _____ DOB _____

Gender: Male _____ Female _____ Phone: H _____ Cell _____

Address _____

Gout Diagnosis: _____ ICD 10 code: _____, _____

Standing Infusion Order:

Krystexxa Dose	8 mg in normal saline 0.9% 250 ml IV over 2 hours - Patient is to be observed for 1 hr post infusion
Schedule	Infuse every two weeks x _____ months.
Labs drawn prior to each treatment 24 - 48 hrs	O Cbc O Cmp (notify MD if Uric Acid is above 6 mg/dL.
Additional blood work requested	O _____
Prior to infusion:	( ) ____ mg Solu-Medro IVP ( ) ____ mg Acetaminophen PO ( ) ____ mg Benadryl IVP or PO (circle preferred) ( ) Other instructions: _____ _____

Prescribing Physician Information:

Name: _____ NPI: _____

Address: _____

Physician Phone: _____ Fax: _____

Physician Signature: _____

Date: _____

*Prior Authorization and Verification of Benefits will be completed by our office.

*Please attach the 3 most recent MD notes, last 3 lab results, demographic sheet (including insurance information) and the completed order form. If any records are unavailable, please let us know.