KRYSTEXXA INFUSION ORDER

INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

G6PD Date: _____/____/____ Result: _____ Uric Test Date:____/____/____ Result:_____

Labs to be drawn by: O Infusion Clinic O Referring Physician

PRE-MEDICATIONS (30 MINUTES BEFORE INFUSION)

Diphenhydramine	O PO	O IV	O 25mg	O 50mg	O PreMed
Acetaminophen:	O PO		O 650mg		O PreMed
Allegra:	O PO		O 60mg		O PreMed
Solu-Medrol		O IV	O 40mg		O PreMed

KRYSTEXXA (PEGLOTICASE) ORDERS

8mg in 250mL 0.9% Sodium Chloride every 2 weeks
ADMINISTER KRYSTEXXA OVER 2 HOURS. Patient will be monitored 1 hour post-infusion.
Infusion Start Date: _____/_____/_____

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994