INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Krystexxa *pegloticase*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Chronic Gout, ICD 10: M1A.

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ G6PD results

☐ Documentation of initiation of Methotrexate and folic acid

☐ Labs and tests supporting diagnosis

☐ Serum uric acid level within 1 month for initiation of therapy, within 48 hours for ongoing treatments

☐ Demographics

☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Krystexxa	8 mg	IV	Every 2 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____