

MRN: _____

**STANDARD KRSTEXXA PLAN OF TREATMENT
For Palmetto Infusion Services Patients**

(Re)Certification Period From _____ to _____

Patient's Name _____ **HT:** _____ **WT** _____ **Allergies:** _____

DIAGNOSIS: Please check one of the following:

- 274.00 Gouty arthropathy, unspecified
- 274.01 Acute gouty arthropathy, including acute gout and flare
- 274.02- Chronic gouty arthropathy w/o mention of tophus (tophi)
- 274.03- Chronic gouty arthropathy with tophus (tophi)

Physician Office to Complete:

1. Has your patient had failure, intolerance, or contraindication to conventional therapy?

- Yes
- No

2. If yes, please specify, treatment/medication tried and outcomes: _____

Premedicate 30 minutes prior to infusion with:

Acetaminophen 650 mg PO, Diphenhydramine 25mg IVP and Methyl prednisone 125 mg IVP

Orders:

Obtain weight each visit. Vital signs every 30 minutes beginning with start of infusion and 60 minutes after infusion complete. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.

Normal Saline Flush 5 ml before and after infusion followed by Heparin Lock 1 – 5 ml 100 units/ml as needed per line type. Pump, tubings, and supplies needed to complete prescribed therapy.

DOSE:

_____ **Krystexxa 8mg in 250 ml Normal Saline over 2hours**

FREQUENCY:

_____ Orders to be completed every 2 weeks.

OTHER:

Lab work prior to each infusion: Serum Uric Acid level- hold infusion if levels are above 6mg/dl.

Pharmacist to perform clinical drug monitoring.

Physician's Signature: _____ / _____ Date: _____

(Dispense as written)

(Substitution permitted)

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to

TOLL FREE FAX (866) 872-8920