Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB: _____

STANDARD KRYSTEXXA PLAN OF TREATMENT

(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:** _____

   _____
3. **Patient has stopped taking any oral urate-lowering therapy?** ☐ **Yes** ☐ **No**
4. **Is patient G6PD deficient?** ☐ **Yes** ☐ **No**

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 2 hours

Frequency:

Orders to be completed every 2 weeks

Other:

Lab work prior to each infusion: Serum Uric Acid level - hold infusion if 2 consecutive levels are above 6mg/dl. If patient misses 2 doses (4 weeks) resuming treatment must be cleared by ordering physician or therapy discontinued.

Pharmacist to perform clinical drug monitoring.

(no stamped signatures please)

Physician's Signature: _____ _____ Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to 866-872-8920