Washington MEDICAL CENTER

FAX: 636-330-2363 Phone: 636-202-9400

KRYSTEXXA pegloticase

REFERRAL STATUS

☐ NEW REFERRAL ☐ ORDER RENEWAL

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐ M ☐ F
WEIGHT: ☐ LBS ☐ KG	PHONE NUMBER:	
ALLERGIES:	EMAIL:	

Please check that the following are included:	Patient demographics and insurance attached	Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	Current Medication List:	

DIAGNOSIS

ICD-10 CODE: M1A☐_____OTHER:	DATE OF LAST INFUSION/INJECTION:

PHYSICIAN INFORMATION

PHYSICIAN NAME:	PHONE NUMBER:
PRACTICE NAME:	FAX NUMBER:
OFFICE CONTACT:	

MEDICATION ORDER

MEDICATION:	DOSING:	FREQUENCY:	NOTES/COMMENTS:
Krystexxa	**8mg**	☐ Initial: Day 1, Week 2, Week 6 ☐ Maintenance: Every 8 weeks ☐ Other:	

PHYSICIAN SIGNATURE _____ DATE (Order is Valid for One Year)

LAB ORDERS

☐ CMP	☐ CBC	☐ CRP	☐ ESR	☐ OTHER

G6P-D (Only necessary prior to first Krystexxa infusion)	Uric acid will be drawn prior to each infusion. If Uric Acid level is above 6, review monitoring protocol. If Uric Acid level is above 6 for consecutive infusions, then stopping rules apply.

PRE MED

☐ Solu-Medrol__mg ☐ Solu-Cortef__mg ☐ Benadryl___mg Tylenol____mg Other _____ ___ mg

TYPES OF ACCESS

☐ Peripheral ☐ PICC ☐ Midline ☐ Port ☐ SQ ☐ I/M