Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Krystexxa (Pegloticase) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] M1A.0 Idiopathic chronic gout
[ ] M1A.3 Chronic gout due to renal impairment
[ ] M1A.4 Other secondary chronic gout
[ ] M1A.9 Chronic gout, unspecified
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, referring office will be notified and HOACNY will not be able to administer the medication.

4. Pre-medications:

[x] Acetaminophen:
[x] **1000mg PO**
[x] Diphenhydramine: (please choose dosage below)
[ ] **25mg PO** [ ] **50mg PO**
[x] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: _____

5. Drug Order: Krystexxa (pegloticase) *Ok to substitute for generic/biosimilar*

Dose/Frequency:
[x] 8mg IV every 2 weeks
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[x] sUA within 48 hours of infusion
[ ] Other: _____

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing Completed**:

[x] G6PD negative, Date: _____
[x] Patient has been off a urate lowering therapy (include drug/dates stopped): _____
[x] Patient has started immunomodulation therapy (Cell Cept or Methotrexate & folic acid) (include drug, dose and start date): _____

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

Physician's Name: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

(This drug administration order form is valid for 12 months)