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: ______________________________

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.

7. **Physician's Name**: ____ **Phone:** ___________________
Physician's Signature: ____**Date:** ________________

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