Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____
Height_____ Weight_____

Infusion Location: (state and Site) _____

Krystexxa® (pegloticase) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):	
_____ Gouty arthropathy (ICD-10)	_____ _____ (ICD-10) (description)
❑ Negative screening for G6PD	❑ Baseline uric acid level & date_____

Nursing Orders:

- Hold infusion pending provider notification if:
  - Uric acid level greater than 6 mg/dL for 2 consecutive treatments (lab orders below).
  - Patient has had more than 4 weeks between treatments (due to increased risk for adverse reaction).
  - Patient reports continued use of uric acid lowering agents (allopurinol, febuxostat, probenecid, etc.)
  - Hypertension (170/90 or symptomatic)
- Remind patient flares may occur during first 6 months of therapy
- Monitor vital signs every 30 minutes during infusion.
- If infusion-related reaction occurs, stop infusion, and initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Labs:

❑ Obtain serum uric acid level prior to each infusion (or may use result obtained within 48 hrs prior to infusion).
❑ Other: _____ **Frequency:** _____

Pre-medications (to be administered once 30 minutes prior to infusion):

❑ Tylenol 500 mg orally	❑ Loratadine 10 mg orally
❑ Solu-Medrol 125 mg IVP	❑ Other:_____

Dosing:
❑ **Krystexxa 8mg IV every 2 weeks with weekly oral methotrexate 15mg and daily folic acid 1mg****
❑ **Methotrexate contraindicated and patient is on Krystexxa Monotherapy 8mg IV every 2 weeks**

****Begin weekly Methotrexate and Folic Acid 4 weeks prior to the start of Krystexxa infusions.****

Observation Period:

- Monitor patient for hypersensitivity reaction for a period of **60 minutes** following each infusion.
- Record vital signs prior to discharge.
- **Frequency:** ☐ Every 2 weeks ☐ Other: _____

Additional Orders:

Provider name (print)_____ Date:_____

Provider signature: _____ Time: _____