Email: intake@infuseone.com | Phone: 1-800-581-0645 |
refer to website www.infuseone.com for location specific fax numbers

Please

INFUSE ONE

(pegloticase)

KRYSTEXXA infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Chronic Gout
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

KRYSTEXXA ORDERS

DOSAGE/FREQUENCY

- ☐ 8mg IV every 2 weeks

PREMEDICATION PER PRESCRIBING INFORMATION

- ☐ Solu-medrol 125mg IV
- ☐ Diphenhydramine 25mg PO

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____