Fax: 561-516-6626 | Email: Info@infuseone.com | Phone: 561-337-4055

(pegloticase)

KRYSTEXXA infusion orders

INFUSE ONE

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 _____

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