ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Center - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Center - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Pegloticase (Krystexxa):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Gout

ICD -10 Code:
❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline Labs Required:

- Screen patients at risk for G6PD deficiency prior to starting pegloticase. Hemolysis and methemoglobinemia have been reported in patients with G6PD deficiency.
- Serum uric acid levels

Maintenance labs required:

- Serum uric acid levels prior to infusions, drawn 24-48 hours before the infusion

Treatment Regimens:

Pegloticase (Krystexxa)

❑ 8 mg IV infusion every 2 weeks as monotherapy or co-administered with weekly oral methotrexate and folic acid supplementation; begin methotrexate and folic acid at least 4 weeks prior to starting pegloticase.

Premeds: ❑ Diphenhydramine 25 mg IVP ❑ Methylprednisolone 40 mg IVP

Dose Adjustments: Discontinue treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.

☑ **Vital signs:** Check vital signs prior to and at completion of dose.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
GOUT

MultiCare

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