Wasatch INFUSION

888.717.7578 801.577.7055

Open 365 days a year • 8am-8pm

BY APPOINTMENT

KRYSTEXXA® pegloticase

LOCATION

☐ Murray ☐ Tooele

REFERRAL STATUS

☐ New Referral ☐ Order Renewal

PATIENT INFORMATION

PATIENT NAME:	DOB: SEX: ☐ M: ☐ F:
WEIGHT: ☐ LBS ☐ KG	PHONE #:
ALLERGIES:	EMAIL:
Please check that the following are included: ○ Patient demographics and insurance attached	○ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
○ Current Medication List	

DIAGNOSIS

ICD-10 CODE: M1A_____ Other:	Date of last infusion/injection:

PHYSICIAN INFORMATION

Physician Name:	Phone Number:
Practice Name:	Fax Number:
Office Contact:	

MEDICATION ORDER

Medication:	Dosing:	Frequency:	Notes/Comments
Krystexxa	**8mg**	☐ Initial: Day 1, Week 2, Week 6 ☐ Maintenance: Every 8 weeks ☐ Other:	

Physician Signature _____ Date (Order is Valid for One Year) _____

LAB ORDERS

☐ G6P-D (Only necessary prior to first Krystexxa infusion)	Uric acid will be drawn prior to each infusion. If Uric Acid level is above 6, review monitoring protocol. If Uric Acid level is above 6 for consecutive infusions, then stopping rules apply.

PREMEDICATIONS

☐ Solu-Medrol ___mg ☐ Solu-Cortef ___mg ☐ Benadryl ___mg ☐ Tylenol ___mg ☐ Other_____ ___mg