BioPlus® Infusion

Fax your completed order to 877-734-1157

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)

☐ G6PD Results_____	☐ 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	☐ Must have Benadryl _____IV or PO per PI

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:_____

Reviewed 4/13/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.