Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Krystexxa® (pegloticase) Infusion Order (Revised 11/5/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ M1A.____ - Chronic gout, without tophi	☐ M1A.____ - Chronic gout with tophi
☐ M10.____ - Idiopathic gout	☐ Other:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Pertinent Diagnostic Studies to Ordered Medication	☐ Yes ☐ No

Treatment Parameters:

☑ Required Lab Results:
- G6PD level PRIOR to first treatment;
- Uric acid level within 72 hours (past 1st infusion) PRIOR to subsequent infusions
(**send labs with order and send uric acid prior to each subsequent infusion**)

☑ Hold Tx and Notify Provider IF:
- G6PD is ABNORMAL or not on file
- Uric acid level is GREATER THAN 6.0mg/dL for 2 consecutive infusions (past 1st infusion) or if labs were not done.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Vital Signs: Upon arrival, PRIOR to treatment, every 30 minutes PRN during treatment, POST treatment, and PRIOR to discharge.

☑ Monitor for any signs of reaction or side effects for 1 hour POST completion treatment.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 1000mg PO ONCE

☐ Diphenhydramine (Benadryl) 50mg PO ONCE

☐ Diphenhydramine (Benadryl) 50mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☑ Pegloticase (Krystexxa) 8mg IV over 120 minutes every 2 weeks

☑ Sodium Chloride 0.9% to run at 50mL/hr IV starting 150 minutes after Krystexxa treatment start time.

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: