

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment**Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:**1. **Diagnosis:** ☐ M1A. _____ 0 Chronic gout ☐ M10. _____ Idiopathic gout ☐ Other: _____2. **Drug Allergies:** _____3. **Failed Medications:** ☐ _____ Therapy Length: _____ Discontinuation Reason: _____☐ _____ Therapy Length: _____ Discontinuation Reason: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Lab work: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider**Pre-Medication Orders:**

- ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
☐ Diphenhydramine ☐ 25mg ☐ 50mg – PO 30 minutes before infusion OR ☐ 25mg IVP ☐ 50mg IVP
☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP or other _____ mg IVP
☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Medication**Krystexxa (pegloticase)**

Dosage:

- ☐
- 8 mg every 2 weeks

☐ **Maintenance Refills:** _____

**** Pre-medications of diphenhydramine IVP and methylprednisolone is recommended prior to infusion****

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ **Physician Signature:** _____ **Date:** _____