Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Krystexxa® (Pegloticase) Treatment Plan

Patient Name: _____ **Patient DOB** _____

Diagnosis-_____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication:

☐ No ☐ Yes, if so, date of last infusion ____/____/_____ and number of previous infusions _____

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)

every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP and prior to discharge

Pre- Treatment Medications (Note: Pre-treatment with acetaminophen oral, diphenhydramine IV push, and methylprednisolone IV push recommended prior to infusion)

Acetaminophen (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Krystexxa (pegloticase)

☑ *8 mg, IV Piggyback, Injection, every 14 days x _____ doses*
Comments: In 250ml 0.45% Sodium Chloride (NS 1/2) infused over 2 hours

☑ Communication Order (Month 1 to 12)

Nursing to ensure patient has not missed previous infusions. If more than 1 previous infusion have been missed (>4 weeks since last infusion) hold dose and notify provider.

☑ Communication Order (Month 1 to 12)

Serum uric acid level to be obtained within 48 hours prior to each infusion. Infusion to be held for provider clearance if two consecutive levels return above 6mg/dL.

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____

Krystexxa® (Pegloticase) Treatment Plan

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 60 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Notify Provider (Month 1 to 12)
Contact provider patient has missed previous infusion and last infusion was >4 weeks prior

☑ Notify Provider (Month 1 to 12)
Contact provider if uric acid levels that are obtained within 48 hours prior to each SUBSEQUENT infusion return above 6mg/dL. (level prior to first infusion may exceed 6 mg/dL)

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing, Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ G6PD testing (if needed)

☑ Uric Acid level (If Needed)

☑ Other: _____

Patient Monitoring Acknowledgement:

***** Referring provider acknowledges that allopurinol and/or febuxostat are recommended to be held for one week prior to infusion. Prophylaxis treatment with colchicine, NSAIDS, or prednisone is recommended to be initiated one week prior and for a minimum of 6 months in duration. Referring provider has screened patient for G6PD deficiency prior to referral initiation, results of G6PD testing must be sent with treatment plan. Pegloticase infusion should be used with caution in patients with heart failure.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____