

INFUSION SUITE		KRYSTEXXA INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
PATIENT INFORMATION - If Outside Referral, Include Patient Demographics and Insurance Cards			
Name:		DOB:	
MEDICAL INFORMATION			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
REQUIRED TESTING			
<input type="checkbox"/> Serum Uric Acid level: _____ (Prior to each infusion) <input type="checkbox"/> G6PD level prior to initiation: _____			
Additional labs:			
<input type="checkbox"/> Insert IV		<input type="checkbox"/> Access Port/PICC	
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:		<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1
<input type="checkbox"/> Diphenhydramine:		<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1
<input type="checkbox"/> Methylprednisolone:		<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1
<input type="checkbox"/> Antihistamine:		<input type="checkbox"/> 650mg PO X1	<input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Additional PRN:		<input type="checkbox"/> 50mg IV X1	<input type="checkbox"/> 50mg PO X1
		<input type="checkbox"/> 125mg IV X1	
		<input type="checkbox"/> Cetirizine 10mg PO X1	<input type="checkbox"/> Loratadine 10mg PO X1
*Diphenhydramine and Solumedrol are required per the PI			
KRYSTEXXA ORDERS			
<input type="checkbox"/> Krystexxa 8mg IV		over 2 hours every 2 weeks X _____	
POST INFUSION			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Discharge home after 1 hour observation time			
<input type="checkbox"/> Discharge home without 1 hour observation time			
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

***Credentials must be included**

Infusion Directions:

- Remove vial and allow to warm to room temperature
- Withdraw 1mL of Krystexxa from the vial and inject into a 250mL bag of NS
- Gently invert to mix. Document and discard any waste
- Infuse over no less than 2 hours, no filter tubing required

Nursing Considerations:

- Confirm patient has discontinued oral urate lowering agents