CURBSIDE
INFUSION SERVICES

Fax To: (877) 428-1627
Email To: referrals@curbsideinfusion.com
Office: (877) 428-7248
Scheduling@curbsideinfusion.com Ext. 0
Billing@curbsideinfusion.com Ext 1

KRYSTEXXA (pegloticase) infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Chronic Gout

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

KRYSTEXXA ORDERS

DOSAGE/FREQUENCY

8mg IV every 2 weeks

PREMEDICATION PER PRESCRIBING INFORMATION

Solu-medrol 125mg IV

Diphenhydramine 25mg PO

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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