

INFUSION SUITE		KRYSTEXXA INFUSION ORDERS		
PATIENT INFORMATION - If Outside Referral, Include Patient Demographics and Insurance Cards				
Name:		DOB:		
MEDICAL INFORMATION				
ICD10 / Diagnosis:		Height:		
Allergies / Hypersensitivities:		Weight (kg):		
		*Weigh patient at each visit		
REQUIRED CLINICAL DOCUMENTATION				
<input checked="" type="checkbox"/> Uric Acid Level *Within 48 hours of infusion <input checked="" 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"/> 650mg PO X1	<input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1	<input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1	
<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Cetirizine 10mg PO X1		<input type="checkbox"/> Loratadine 10mg PO X1	
<input type="checkbox"/> Additional PRN:				
KRYSTEXXA ORDERS				
<input type="checkbox"/> Krystexxa 8mg IV in 250mL NS over 2 hours every _____ 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 following 1 hour observation <input type="checkbox"/> Discharge home without observation				
Signature:		Date:		
Provider Name/Credentials: <input type="checkbox"/>		Provider Phone:		
Provider Name/Credentials: <input type="checkbox"/>		Provider Name/Credentials: <input type="checkbox"/>		
Provider Name/Credentials: <input type="checkbox"/>		Provider Name/Credentials: <input type="checkbox"/>		
Provider Name/Credentials: <input type="checkbox"/>		Provider Name/Credentials: <input type="checkbox"/>		

Nursing Considerations:

- Confirm patient has discontinued oral urate lowering agents
- Notify provider if uric acid level is over 6 for 2 consecutive treatments

Infusion Directions:

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