FUSE INFUSION

175 Memorial Highway. Suite 1-1
New Rochelle, NY
10801

914-460-4891
fuse@fuseinfusion.com
914-460-4571

(pegloticase)

KRYSTEXXA infusion orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ __________ Chronic Gout

☐ __________ ______________________________ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg IV

☐ Cetirizine 10mg IV

☐ ______________________________ *(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 IV

PATIENT WEIGHT

________ lbs.

________ kg

NOTES

____

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ______________________________ Phone ____________ Fax ____________

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