Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 ADULT AMBULATORY INFUSION ORDER **Pegloticase (KRYSTEXXA) Infusion** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. **Within 48 hours prior to each treatment, uric acid level must be obtained and results must be provided to the infusion clinic**. Anaphylaxis reactions have occurred. Risk of an infusion reaction is increased if patient uric acid is greater than 6 mg/dL. Discontinue treatment if levels exceed 6 mg/dL for 2 consecutive levels.
3. Prior to treatment initiation, Glucose-6-phosphate dehydrogenase (G6PD) serum test results must be included with these orders. Contraindication for G6PD deficiency, due to the risk of hemolysis and methemoglobinemia.
4. Discontinue use of oral antihyperuricemic agents prior to initiating and during course of therapy.
5. Gout Flares: Begin prophylaxis using nonsteroidal anti-inflammatory agents (NSAID) or colchicine, unless contraindicated, beginning at least 1 week before initiation of pegloticase and continuing for at least 6 months. An increase in gout flares is frequently observed. Gout flare-ups during treatment do not warrant discontinuation of therapy.
6. Congestive Heart Failure: Exercise caution in patients who have congestive heart failure and monitor patients closely following infusion.

LABS:

- ☐ Glucose-6-Phosphate Dehydrogenase, Routine, ONCE
- ☐ Uric Acid, Routine, ONCE, every visit

NURSING ORDERS:

1. TREATMENT PARAMETERS - Hold treatment and notify provider:
    a. If G6PD results are not available prior to initiation
    b. If uric acid level is not obtained within 48 hours prior to each treatment or if uric acid is greater than 6 mg/dL (Treatment should be discontinued if 2 or more consecutive uric acid levels are greater than 6 mg/dL)
    c. If patient misses 2 consecutive treatments (4 weeks). Provider must approve continuing therapy or treatment will be discontinued
2. VITAL SIGNS – Monitor vital signs prior to pegloticase infusion, one hour into infusion, and at end of infusion.
3. Allow pegloticase ready-to-use (RTU) vial to reach room temperature prior to administration. Do not warm to room temperature using any form of artificial heating. Protect from light. Do not shake. Pegloticase should be used within 4 hours.

4. An infusion pump must be used for administration of the Ready-to-Use (RTU) vial over a period of no less than 2 hours. After the contents of the vial are administered, flush line with Normal Saline to ensure delivery of required dose.
5. Monitor patient closely for infusion reactions during pegloticase infusion and for 1 hour after the infusion. Advise patient that delayed hypersensitivity reactions may occur. For patients with heart failure, exacerbations can occur. Educate patient on signs and symptoms of infusion reaction, including skin rash, redness of skin, difficulty breathing, flushing, chest discomfort, chest pain, and rash.
6. Explain to patient that gout flares may initially increase when starting treatment, and medications to help reduce flares may need to be taken regularly for the first few months after therapy is started. Advise patient to continue therapy even if there are flares.
7. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
  Give either loratadine or diphenhydrAMINE, not both.
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 40 mg, intravenous, ONCE, every visit.

MEDICATIONS:

- pegloticase (KRYSTEXXA) 8 mg/50 mL (RTU), intravenous, over 2 hours, ONCE

  Interval:
  - ☐ Every 2 weeks for ____ doses
  - ☐ Every 2 weeks until discontinued

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or malaise from pegloticase
2. diphenhydrAMINE (BENADRYL) tablet, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching from pegloticase

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**