Care Fusion INFUSION CENTERS

AIC Podiatry **Fax: 855-733-9898**
Phone: 877-460-3905

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: ____ Patient Contact #: _____

Medical Assessment

Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** □ M1A._____0 Chronic gout □ M10. _____ Idiopathic gout □ Other: _____
2. **Drug Allergies:** _____
3. **Failed Medications:** □ _____ Therapy Length: _____ Discontinuation Reason: _____
   □ _____ Therapy Length: _____ Discontinuation Reason: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Lab work: _____ To be Drawn by: Infusion Clinic Referring Provider

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Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □ 180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other _____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Medication

Krystexxa (pegloticase)

Dosage:

- ❑ 8 mg every 2 weeks
- ❑ **Maintenance Refills**: ___

** Pre-medications of diphenhydramine IVP and methylprednisolone is recommended prior to infusion**

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____Physician Name: _____

NPI #_____***Physician Signature:*** _____***Date:*** _____