HORIZON BY your side | KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:

1. Fill out all required fields as indicated by the asterisks, including the signature and date within the Prescriber Certification section. **If you need help with a section, click on its corresponding number (1-9) for more information**
2. Obtain the patient signature and date of signature within the Patient Authorization section, if possible
3. Send both the front and back of the patient's insurance card(s) along with the completed form to Horizon By Your Side

***The patient's signature is required to complete the enrollment process.**

INDICATION

KRYSTEXXA® (pegloticase) is indicated for the treatment of chronic gout in adult patients who have failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled with xanthine oxidase inhibitors at the maximum medically appropriate dose or for whom these drugs are contraindicated.

Limitations of Use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

IMPORTANT SAFETY INFORMATION

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS, G6PD DEFICIENCY ASSOCIATED HEMOLYSIS AND METHEMOGLOBINEMIA

- **Anaphylaxis and infusion reactions have been reported to occur during and after administration of KRYSTEXXA.**
- **Anaphylaxis may occur with any infusion, including a first infusion, and generally manifests within 2 hours of the infusion. Delayed hypersensitivity reactions have also been reported.**
- **KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.**
- **Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for an appropriate period after administration of KRYSTEXXA.**
- **Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.**
- **Screen patients at risk for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. KRYSTEXXA is contraindicated in patients with G6PD deficiency.**

Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

Patient Enrollment Form

Once complete, submit by fax **1-877-633-9522** or email **GoutHBYS@horizontherapeutics.com**

HORIZON BY your side | KRYSTEXXA pegloticase

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process.

For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-877-633-9521.

1 Patient Information (*Indicates a required field)

First name*: Stephen
Last name*: Patient
Sex*: (●) Male ( ) Female
Date of birth*: 05/16/1957 (MM/DD/YYYY)
Primary language: English
Email address: stephenpatient@email.com
Primary telephone*: 555-123-1234
( ) Home (●) Cell
Consent to leave voice message at patient and/or alternate contact telephone? (●) Yes ( ) No
Consent to send text message? (●) Yes ( ) No
Address*: 123 Main Street
City*: Lake Forest
State*: IL
ZIP code*: 60045
Alternate contact name: Jane Spouse
Alternate contact telephone: 555-234-5678

2 Insurance Information (*Indicates a required field) (Please include front and back copies of insurance card[s] with this form)

Primary insurance*: Insurance Provider 1
Secondary insurance, if applicable: Insurance Provider 2
Policy #*: 1234567
Policy #: 9876543
Policyholder's first and last name*: Stephen Patient
Policyholder's first and last name: Jane Spouse
Insurance company telephone*: 800-123-4567
Insurance company telephone: 888-123-4567
Group #*: 000001
Group #: 000002
Policyholder's DOB*: 05/16/1957 (MM/DD/YYYY)
Policyholder's DOB: 01/01/1960 (MM/DD/YYYY)
IPA/Medical group name: IPA/Medical Group
IPA/Medical group telephone: 877-555-1234
☐ Reverification request
☐ Patient is uninsured to my knowledge

3 Infusion Facility (*Indicates a required field)

Do you have a preferred infusion facility?* (●) Yes ( ) No If yes, please fill out the preferred infusion facility information below. If no, Horizon By Your Side will help identify a facility in close proximity to your patient.
☐ The infusion facility is the same as the prescribing office
Facility name*: Infusion Center
Facility address*: 123 Facility Drive
City*: Chicago
State*: IL
ZIP code*: 60601
Telephone*: 555-123-1111
Fax*: 555-123-1112
Facility NPI #*: 0000000009
Facility tax ID #*: 00-00000008

4 Patient Authorization (Required – please see authorization language on page 2)

Patient signature: Stephen Patient
Please read page 2
Date: 07/01/2022 (MM/DD/YYYY)
Printed full name: Stephen Patient

5 Prescriber Information (*Indicates a required field)

First name*: John
Last name*: Prescriber
Address*: 123 Medical Way
City*: Deerfield
State*: IL
ZIP code*: 60016
NPI #*: 0000000000
Tax ID #*: 00-0000000
State license #*: 12121212
Clinic/hospital affiliation: Memorial Hospital
Office contact name: Jenny Assistant
Office contact telephone*: 555-123-0987
Fax*: 555-123-4567
Email address*: johnprescriber@email.com
Preferred communication: ( ) Telephone (●) Email
Prescriber specialty*: Rheumatology
Referring healthcare provider: Was this patient referred to you by another HCP? ( ) Yes (●) No If yes, please populate:
Name:
Specialty:
City:
State:
ZIP code:
Telephone:

6 Diagnosis (Required for benefits investigation) (*Indicates a required field)

Primary diagnosis code*: **M1A.** 00X1 — **Chronic Gout**
(Use coding wheel or see full list of codes at ChronicGoutCodes.com)
Additional disease manifestation codes: N/A

7 Co-administration Medication

Is there an immunomodulator prescribed? (●) Yes ( ) No If yes, please indicate below:
(●) methotrexate ( ) Other

8 Prescription Information (Required for specialty pharmacy benefit) (*Indicates a required field)

Dose: KRYSTEXXA® (pegloticase) injection, 8 mg/mL, for intravenous infusion every two weeks
Vial quantity*: 2
Refills*: 6
Allergies*: or ☑ No known drug allergies (NKDA)
☑ Authorize administration supplies as needed

Contraindications:
- Patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Patients with a history of serious hypersensitivity reactions, including anaphylaxis, to KRYSTEXXA or any of its components

Administration: The KRYSTEXXA admixture should only be administered by intravenous infusion over no less than 120 minutes via gravity feed, syringe-type pump, or infusion pump. Do not administer as an intravenous push or bolus. Please refer to the KRYSTEXXA Full Prescribing Information on preinfusion medications and how to reconstitute and dilute KRYSTEXXA for intravenous (IV) infusion.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

9 Prescriber Certification (Required – please see certification language on page 2)

Prescriber signature / Dispense as written*: John Prescriber
Substitutions allowed:
Written or e-signature only; stamps not acceptable.
Date*: 07/01/2022 (MM/DD/YYYY)
☑ **I certify that the above therapy is medically necessary for the treatment of documented uncontrolled gout.***
The above signature grants permission to share records with the referring office and infusion facility.

Please see Important Safety Information on page 2 and see Full Prescribing Information, including Boxed Warning, at KRYSTEXXAhcp.com.

P-KRY-US-00253 07/22

Visit GoutEnroll.com to download and complete a digital version of the Patient Enrollment Form

HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:

1 Patient Information

Provide the patient's demographic and contact information.

- Required fields are needed to conduct a benefits investigation, contact the patient for any follow-up, and provide support from Horizon By Your Side
- Alternate contact information is optional
  - It may be helpful to include a caregiver's contact information here

1 Patient Information (*Indicates a required field)

Stephen **First name***	Patient **Last name***
Sex*: (●) Male ( ) Female	**Date of birth*:** 05/16/1957 (MM/DD/YYYY)
English Primary language	stephenpatient@email.com Email address
555-123-1234 **Primary telephone***	Consent to leave voice message at patient and/or alternate contact telephone? (●) Yes ( ) No
( ) Home (●) Cell	Consent to send text message? (●) Yes ( ) No

123 Main Street
Address*

Lake Forest **City***	IL **State***	60045 **ZIP code***
Jane Spouse Alternate contact name	555-234-5678 Alternate contact telephone	

*The patient

INDICATION

KRYSTEXXA® ... serum uric ac... maximum me...

Limitations of use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

IMPORTANT SAFETY INFORMATION

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS, G6PD DEFICIENCY ASSOCIATED HEMOLYSIS AND METHEMOGLOBINEMIA

- Anaphylaxis and infusion reactions have been reported to occur during and after administration of KRYSTEXXA.
- Anaphylaxis may occur with any infusion, including a first infusion, and generally manifests within 2 hours of the infusion. Delayed hypersensitivity reactions have also been reported.
- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for an appropriate period after administration of KRYSTEXXA.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.
- Screen patients at risk for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. KRYSTEXXA is contraindicated in patients with G6PD deficiency.

Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

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HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

2 Insurance Information

Provide the patient's primary insurance information, which is required to conduct a benefits investigation. Results will be delivered after the patient's authorization is received.

✓ Please include the front and back of your patient's insurance card(s), if available, along with the completed Patient Enrollment Form

- Include secondary insurance information, if applicable, to improve the accuracy of the benefits investigation
- If requesting a reverification of benefits for a patient who has already been enrolled, fill in the box next to "Reverification request"
- If the patient does not have any insurance, fill in the box next to "Patient is uninsured to my knowledge"

2 Insurance Information (*Indicates a required field) (Please include front and back copies of insurance card[s] with this form)

Primary	Secondary
Insurance Provider 1 — **Primary insurance***	Insurance Provider 2 — Secondary insurance, if applicable
1234567 — **Policy #***	9876543 — Policy #
Stephen Patient — **Policyholder's first and last name***	Jane Spouse — Policyholder's first and last name
800-123-4567 — **Insurance company telephone***	888-123-4567 — Insurance company telephone
000001 — **Group #***	000002 — Group #
Policyholder's DOB*: 05/16/1957 (MM/DD/YYYY)	Policyholder's DOB: 01/01/1960 (MM/DD/YYYY)
IPA/Medical Group — IPA/Medical group name	877-555-1234 — IPA/Medical group telephone

☐ Reverification request

☐ Patient is uninsured to my knowledge

- Anaphylaxis may occur with any infusion, including a first infusion, and generally manifests within 2 hours of the infusion. Delayed hypersensitivity reactions have also been reported.
- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for an appropriate period after administration of KRYSTEXXA.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.
- Screen patients at risk for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. KRYSTEXXA is contraindicated in patients with G6PD deficiency.

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HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:

1 Fill out all required fields as indicated by the asterisks, including the signature and date within the Pres... num...

2 Obt...

3 Sen... Hor...

*The patient...

3 Infusion Facility

Indicate whether you have a preference for the infusion facility where your patient will receive KRYSTEXXA.

- If you do not have a preference, Horizon By Your Side will provide options based on the patient's insurance and proximity to the patient

INDICATION

KRYSTEXXA® ... normalize serum uric a... the maximum medically appropriate dose or for whom these drugs are contraindicated.

Limitations of Use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

IMPORTANT SAFETY INFORMATION

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS, G6PD DEFICIENCY ASSOCIATED HEMOLYSIS AND METHEMOGLOBINEMIA

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- **Anaphylaxis may occur with any infusion, including a first infusion, and generally manifests within 2 hours of the infusion. Delayed hypersensitivity reactions have also been reported.**
- **KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.**
- **Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for an appropriate period after administration of KRYSTEXXA.**
- **Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.**
- **Screen patients at risk for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. KRYSTEXXA is contraindicated in patients with G6PD deficiency.**

Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

Patient Enrollment Form
Once complete, submit by fax 1-877-633-9522 or email GoutHBYS@horizontherapeutics.com

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process.
For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-877-633-9521.

1 Patient Information (*Indicates a required field)

First name*: Stephen | Last name*: Patient
Sex*: (●) Male ( ) Female | Date of birth*: 05/16/1957 (MM/DD/YYYY)
Primary language: English | Email address: stephenpatient@email.com
Primary telephone*: 555-123-1234 | Consent to leave voice message at patient and/or alternate contact telephone? (●) Yes ( ) No
( ) Home (●) Cell | Consent to send text message? (●) Yes ( ) No
Address*: 123 Main Street

5 Prescriber Information (*Indicates a required field)

First name*: John | Last name*: Prescriber
Address*: 123 Medical Way
City*: Deerfield | State*: IL | ZIP code*: ...0016
NPI #*: 0000000000 | Tax ID #*: 00-0000000 | State license #*: 12121212
Clinic/hospital affiliation: Memorial Hospital
Office contact name: Jenny Assistant
Office contact telephone*: 555-123-0987 | Fax*: 555-123-4567
Email address*: johnprescriber@email.com
Preferred communication: ( ) Telephone (●) Email | Prescriber specialty*: Rheumatology

3 Infusion Facility (*Indicates a required field)

Do you have a preferred infusion facility?* (●) Yes ( ) No If yes, please fill out the preferred infusion facility information below. If no, Horizon By Your Side will help identify a facility in close proximity to your patient.

☐ The infusion facility is the same as the prescribing office

Facility name*: Infusion Center
Facility address*: 123 Facility Drive
City*: Chicago | **State***: IL | **ZIP code***: 60601
Telephone*: 555-123-1111 | **Fax***: 555-123-1112
Facility NPI #*: 0000000009 | **Facility tax ID #***: 00-00000008

Administration: The KRYSTEXXA admixture should only be administered by intravenous infusion over no less than 120 minutes via gravity feed, syringe-type pump, or infusion pump. Do not administer as an intravenous push or bolus. Please refer to the KRYSTEXXA Full Prescribing Information on preinfusion medications and how to reconstitute and dilute KRYSTEXXA for intravenous (IV) infusion.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

4 Patient Authorization (Required – please see authorization language on page 2)

Patient signature: Stephen Patient | Date: 07/01/2022 (MM/DD/YYYY)
Please read page 2
Printed full name: Stephen Patient

9 Prescriber Certification (Required – please see certification language on page 2)

Prescriber signature / Dispense as written*: John Prescriber | Substitutions allowed
Written or e-signature only; stamps not acceptable.
Date*: 07/01/2022 (MM/DD/YYYY)
☑ I certify that the above therapy is medically necessary for the treatment of documented uncontrolled gout.*
The above signature grants permission to share records with the referring office and infusion facility.

Please see Important Safety Information on page 2 and see Full Prescribing Information, including Boxed Warning, at KRYSTEXXAhcp.com.

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Visit GoutEnroll.com to download and complete a digital version of the Patient Enrollment Form

HORIZON BY your side | KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:

4 Patient Authorization

The Patient Authorization information is located on the second page of the form.

- A patient signature and date of signature are required to complete enrollment in Horizon By Your Side, which provides non-medical, logistical support
- If the patient can't sign the form at your office, Horizon By Your Side can follow up to obtain consent

4 Patient Authorization (Required – please see authorization language on page 2)

Stephen Patient — **Patient signature** — Please read page 2

Date: 07/01/2022 (MM/DD/YYYY)

Stephen Patient — **Printed full name**

Patient Enrollment Form
Once complete, submit by fax **1-877-633-9522** or email **GoutHBYS@horizontherapeutics.com**

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process.
For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-877-633-9521.

1 Patient Information (*Indicates a required field)

Field	Value
First name*	Stephen
Last name*	Patient
Sex*	Male
Date of birth* (MM/DD/YYYY)	05/16/1957
Primary language	English
Email address	stephenpatient@email.com
Primary telephone*	555-123-1234 (Cell)
Consent to leave voice message at patient and/or alternate contact telephone?	Yes
Consent to send text message?	Yes
Address*	123 Main Street
City*	Lake Forest
State*	IL
ZIP code*	60045
Alternate contact name	Jane Spouse
Alternate contact telephone	555-234-5678

2 Insurance Information (*Indicates a required field) (Please include front and back copies of insurance card[s] with this form)

5 Prescriber Information (*Indicates a required field)

Field	Value
First name*	John
Last name*	Prescriber
Address*	123 Medical Way
City*	Deerfield
State*	IL
ZIP code*	60016
NPI #*	0000000000
Tax ID #*	00-0000000
State license #*	12121212
Clinic/hospital affiliation	Memorial Hospital
Office contact name	Jenny Assistant
Office contact telephone*	555-123-0987
Fax*	555-123-4567
Email address*	johnprescriber@email.com
Preferred communication	Email
Prescriber specialty*	Rheumatology

Referring healthcare provider: Was this patient referred to you by another HCP? No. If yes, please populate: Name: Specialty: City: State:

The infusion facility is the same as the prescribing office

Field	Value
Facility name*	Infusion Center
Facility address*	123 Facility Drive
City*	Chicago
State*	IL
ZIP code*	60601
Telephone*	555-123-1111
Fax*	555-123-1112
Facility NPI #*	0000000009
Facility tax ID #*	00-00000008

No known drug allergies (NKDA)

☑ Authorize administration supplies as needed

Contraindications:
- Patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Patients with a history of serious hypersensitivity reactions, including anaphylaxis, to KRYSTEXXA or any of its components

Administration: The KRYSTEXXA admixture should only be administered by intravenous infusion over no less than 120 minutes via gravity feed, syringe-type pump, or infusion pump. Do not administer as an intravenous push or bolus. Please refer to the KRYSTEXXA Full Prescribing Information on preinfusion medications and how to reconstitute and dilute KRYSTEXXA for intravenous (IV) infusion.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

4 Patient Authorization (Required – please see authorization language on page 2)

Stephen Patient — **Patient signature** — Please read page 2 — **Date:** 07/01/2022 (MM/DD/YYYY)

Stephen Patient — **Printed full name**

9 Prescriber Certification (Required – please see certification language on page 2)

John Prescriber — **Prescriber signature / Dispense as written*** — Substitutions allowed

Written or e-signature only; stamps not acceptable.

Date*: 07/01/2022 (MM/DD/YYYY)

☑ **I certify that the above therapy is medically necessary for the treatment of documented uncontrolled gout.***
The above signature grants permission to share records with the referring office and infusion facility.

Please see Important Safety Information on page 2 and see Full Prescribing Information, including Boxed Warning, at KRYSTEXXAhcp.com.

P-KRY-US-00253 07/22

Page 1 of 2

Visit GoutEnroll.com to download and complete a digital version of the Patient Enrollment Form

*The patient

INDICATION

Limitations of Use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

IMPORTANT SAFETY INFORMATION

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Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRY...

5 Prescriber Information

Provide the prescriber's name, contact information, NPI, tax ID, and state license numbers, which are required for processing.

- Include the office contact name to ensure proper follow-up
- **Important:** complete the referring healthcare provider section if there is another HCP involved in the patient's treatment
  - Fill in the name of the HCP as well as their specialty and address

Prescriber Information (*Indicates a required field) 5

First name*: John	Last name*: Prescriber	
Address*: 123 Medical Way		
City*: Deerfield	State*: IL	ZIP code*: 60016
NPI #*: 0000000000	Tax ID #*: 00-0000000	State license #*: 12121212
Clinic/hospital affiliation: Memorial Hospital		
Office contact name: Jenny Assistant		
Office contact telephone*: 555-123-0987	Fax*: 555-123-4567	
Email address*: johnprescriber@email.com		

Preferred communication: ○ Telephone ● Email **Prescriber specialty*:** Rheumatology

Referring healthcare provider: Was this patient referred to you by another HCP? ○ Yes ● No If yes, please populate:

Name: ______ Specialty: ______

City: ______ State: ______

ZIP code: ______ Telephone: ______

*The patient...

INDICATION

KRYSTEXXA® ... serum uric ac... maximum me... Limitations of...

IMPORTANT SAFETY INFORMATION

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS, G6PD DEFICIENCY ASSOCIATED HEMOLYSIS AND METHEMOGLOBINEMIA

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HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

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1. Fill out all required fields as indicated by the asterisks, including the signature and date within the Prescriber Certification section. **If you need help with a section, click on its corresponding num...**
2. Obt...
3. Sen... Hor...

*The patient...

6 Diagnosis

Confirm the diagnosis code. This is required to conduct a benefits investigation.

- Add additional disease manifestation codes, if applicable

Diagnosis **(Required for benefits investigation) (*Indicates a required field)** 6

Primary diagnosis code*: **M1A.** 00X1 — **Chronic Gout**

(Use coding wheel or see full list of codes at ChronicGoutCodes.com)

Additional disease manifestation codes: N/A

INDICATION

KRYSTEXXA® (pegloticase) is indicated for the treatment of chronic gout in adult patients who have failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled with xanthine oxidase inhibitors at the maximum medically appropriate dose or for whom these drugs are contraindicated.

Limitations of Use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

IMPORTANT SAFETY INFORMATION

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Patient Enrollment Form
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For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-877-633-9521.

1 **Patient Information** (*Indicates a required field)

First name*: Stephen | Last name*: Patient
Sex*: (•) Male ( ) Female | Date of birth*: 05/16/1957 (MM/DD/YYYY)
Primary language: English | Email address: stephenpatient@email.com
Primary telephone*: 555-123-1234 ( ) Home (•) Cell | Consent to leave voice message at patient and/or alternate contact telephone? (•) Yes ( ) No | Consent to send text message? (•) Yes ( ) No
Address*: 123 Main Street
City*: Lake Forest | State*: IL | ZIP code*: 60045
Alternate contact name: Jane Spouse | Alternate contact telephone: 555-234-5678

2 **Insurance Information** (*Indicates a required field) (Please include front and back copies of insurance card(s) with this form)

Primary insurance*: Insurance Provider 1 | Secondary insurance, if applicable: Insurance Provider 2

Do you have a preferred infusion facility?* (•) Yes ( ) No If yes, please fill out the preferred infusion facility information below. If no, Horizon By Your Side will help identify a facility in close proximity to your patient.
[ ] The infusion facility is the same as the prescribing office
Facility name*: Infusion Center
Facility address*: 123 Facility Drive
City*: Chicago | State*: IL | ZIP code*: 60601
Telephone*: 555-123-1111 | Fax*: 555-123-1112
Facility NPI #*: 0000000009 | Facility tax ID #*: 00-00000008

4 **Patient Authorization** (Required – please see authorization language on page 2)

Patient signature: Stephen Patient | Date: 07/01/2022 (MM/DD/YYYY)
Please read page 2
Printed full name: Stephen Patient

Please see Important Safety Information on page 2 and see Full Prescribing Information, including Boxed Warning, at KRYSTEXXAhcp.com.

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5 **Prescriber Information** (*Indicates a required field)

First name*: John | Last name*: Prescriber
Address*: 123 Medical Way
City*: Deerfield | State*: IL | ZIP code*: 60015
NPI #*: 0000000000 | Tax ID #*: 00-0000000 | State license #*: 12121212
Clinic/hospital affiliation: Memorial Hospital
Office contact name: Jenny Assistant
Office contact telephone*: 555-123-0987 | Fax*: 555-123-4567
Email address*: johnprescriber@email.com
Preferred communication: ( ) Telephone (•) Email | Prescriber specialty*: Rheumatology
Referring healthcare provider: Was this patient referred to you by another HCP? ( ) Yes (•) No If yes, please populate:
Name: | Specialty:
City: | State:
ZIP code: | Telephone:

6

7

8

Vial quantity*: | Refills*:
Allergies*: or [x] No known drug allergies (NKDA)
[x] Authorize administration supplies as needed
Contraindications:
- Patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Patients with a history of serious hypersensitivity reactions, including anaphylaxis, to KRYSTEXXA or any of its components

Administration: The KRYSTEXXA admixture should only be administered by intravenous infusion over no less than 120 minutes via gravity feed, syringe-type pump, or infusion pump. Do not administer as an intravenous push or bolus. Please refer to the KRYSTEXXA Full Prescribing Information on preinfusion medications and how to reconstitute and dilute KRYSTEXXA for intravenous (IV) infusion.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

9 **Prescriber Certification** (Required – please see certification language on page 2)

Prescriber signature / Dispense as written*: John Prescriber | Substitutions allowed
Written or e-signature only; stamps not acceptable.
Date*: 07/01/2022 (MM/DD/YYYY)
[x] I certify that the above therapy is medically necessary for the treatment of documented uncontrolled gout.*
The above signature grants permission to share records with the referring office and infusion facility.

Page 1 of 2

Visit GoutEnroll.com to download and complete a digital version of the Patient Enrollment Form

HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:

1. Fill out all required fields as indicated by the asterisks, including the signature and date within the Prescriber Certification section. **If you need help with a section, click on its corresponding number (1-9) for more information**

2. Obt

3. Sen Hor

*The patient

7 Co-administration Medication

Confirm if an immunomodulator was prescribed and, if so, indicate methotrexate or other.

Co-administration Medication 7

Is there an immunomodulator prescribed? ◉ Yes ○ No If yes, please indicate below:

◉ methotrexate ○ Other

INDICATION

KRYSTEXXA® (pegloticase) is indicated for the treatment of chronic gout in adult patients who have failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled with xanthine oxidase inhibitors at the maximum medically appropriate dose or for whom these drugs are contraindicated.

Limitations of Use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

IMPORTANT SAFETY INFORMATION

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS, G6PD DEFICIENCY ASSOCIATED HEMOLYSIS AND METHEMOGLOBINEMIA

- Anaphylaxis and infusion reactions have been reported to occur during and after administration of KRYSTEXXA.
- Anaphylaxis may occur with any infusion, including a first infusion, and generally manifests within 2 hours of the infusion. Delayed hypersensitivity reactions have also been reported.
- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for an appropriate period after administration of KRYSTEXXA.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels increase above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.
- Screen patients at risk for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. KRYSTEXXA is contraindicated in patients with G6PD deficiency.

Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

Patient Enrollment Form
Once complete, submit by fax 1-877-633-9522 or email GoutHBYS@horizontherapeutics.com

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process.
For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-877-633-9521.

1 Patient Information (*Indicates a required field)

2 Insurance Information

4 Patient Authorization

5 Prescriber Information (*Indicates a required field)

6

7

8

9 Prescriber Certification

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Page 1 of 2

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2 Obt…

3 Sen… Hor…

*The patient…

8 Prescription Information

For a specialty pharmacy benefit, this section should be completed.

Prescription Information (Required for specialty pharmacy benefit) (*Indicates a required field) **8**

Dose: KRYSTEXXA® (pegloticase) injection, 8 mg/mL, for intravenous infusion every two weeks

Vial quantity*: 2 **Refills*:** 6

Allergies*: ______ or ☑ No known drug allergies (NKDA)

☑ Authorize administration supplies as needed

Contraindications:

- Patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Patients with a history of serious hypersensitivity reactions, including anaphylaxis, to KRYSTEXXA or any of its components

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INDICATION

KRYSTEXXA® (pegloticase) is indicated for the treatment of chronic gout in adult patients who have failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled with xanthine oxidase inhibitors at the maximum medically appropriate dose or for whom these drugs are contraindicated.

Limitations of Use: KRYSTEXXA is not recommended for the treatment of asymptomatic hyperuricemia.

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5 Prescriber Information (*Indicates a required field)

4 Patient Authorization (Required – please see authorization language on page 2)

9 Prescriber Certification (Required – please see certification language on page 2)

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Page 1 of 2

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HORIZON BY your side

KRYSTEXXA pegloticase

Patient Enrollment Form Guide

Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:

9 Prescriber Certification

Completion of the Prescriber Certification is required for processing the Patient Enrollment Form.

- Ensure that the prescriber has signed and dated the form, and checked the appropriate attestation box
  - The attestation confirms that the therapy is medically necessary for documented uncontrolled gout

Prescriber Certification (Required – please see certification language on page 2) 9

John Prescriber

Prescriber signature / Dispense as written* Substitutions allowed

Written or e-signature only; stamps not acceptable.

Date*: 07/01/2022 (MM/DD/YYYY)

☑ **I certify that the above therapy is medically necessary for the treatment of documented uncontrolled gout.***
The above signature grants permission to share records with the referring office and infusion facility.

INDICATION

KRYSTEXXA® ... serum uric ac... maximum m...

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CONTRAINDICATIONS:

- In patients with G6PD deficiency.
- In patients with history of serious hypersensitivity reactions, including anaphylaxis, to KRYSTEXXA or any of its components.

WARNINGS AND PRECAUTIONS

Gout Flares: An increase in gout flares is frequently observed upon initiation of anti-hyperuricemic therapy, including KRYSTEXXA. Gout flare prophylaxis with a non-steroidal anti-inflammatory drug (NSAID) or colchicine is recommended starting at least 1 week before initiation of KRYSTEXXA therapy and lasting at least 6 months, unless medically contraindicated or not tolerated.

Congestive Heart Failure: KRYSTEXXA has not been formally studied in patients with congestive heart failure, but some patients in the pre-marketing placebo-controlled clinical trials experienced exacerbation. Exercise caution in patients who have congestive heart failure and monitor patients closely following infusion.

ADVERSE REACTIONS

The most commonly reported adverse reactions (≥5%) are:

KRYSTEXXA co-administration with methotrexate trial:
KRYSTEXXA with methotrexate: gout flares, arthralgia, COVID-19, nausea, and fatigue; KRYSTEXXA alone: gout flares, arthralgia, COVID-19, nausea, fatigue, infusion reaction, pain in extremity, hypertension, and vomiting.

KRYSTEXXA pre-marketing placebo-controlled trials:
gout flares, infusion reactions, nausea, contusion or ecchymosis, nasopharyngitis, constipation, chest pain, anaphylaxis, and vomiting.

For additional information on KRYSTEXXA, please see Full Prescribing Information, including Boxed Warning, at KRYSTEXXAhcp.com.

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