

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



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



Obtain the patient signature and date of signature within the Patient Authorization section, if possible

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

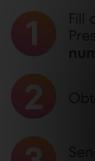
Once complete, submit by fax 1-877-633-9522 or ail GoutHBYS@horizontherapeutic

	3-9521.	John	Prescriber
		First name*	Last name*
Patient Information (*Indicates	a required field)	123 Medical Way Address*	
Stephen	Patient	Deerfield City*	
First name*	Last name*	000000000 00-00000	000 12121212
Sex*: 🔘 Male 🔿 Female	Date of birth*: 05/16/1957	NPI #* Tax ID #*	State license #*
0 0 0	(MM/DD/YYYY)	Memorial Hospital	
English	stephenpatient@email.com Email.address	Clinic/hospital affiliation	
Primary language	Email adaress	Jenny Assistant	
Cons	sent to leave voice message at patient	Office contact name 555-123-0987	555-123-4567
555-123-1234 and/ Primary telephone*	or alternate contact telephone? 💿 Yes 🔾 No	Office contact telephone*	
		johnprescriber@email.com	
Home O Cell Cons	sent to send text message? • Yes	Email address*	
123 Main Street			Email Prescriber specialty*: Rheumatology
Address*			Ender Prescriber speciality
Lake Forest City*		Referring healthcare provider: Was this patient	
Jane Spouse	555-234-5678	referred to you by another HCP?	Yes 💿 No If yes, please populate:
Alternate contact name	Alternate contact telephone	Name:	Specialty:
/*!	ates a required field) (Please include front and		
	ates a required field) (Please include front and opies of insurance card[s] with this form)	City:	State:
		ZIP code:	Telephone:
Insurance Provider 1	Insurance Provider 2	211 COQ8.	
Primary insurance*	Secondary insurance, if applicable	Required for benefits inves	tigation)
1234567 Policy #*	9876543 Policy #	Diagnosis (*Indicates a required field)	
•	,	001	
Stephen Patient Policyholder's first and last name*	Jane Spouse Policyholder's first and last name	, .	— Chronic Gout
800-123-4567	888-123-4567	(Use coding wheel or	r see full list of codes at ChronicGoutCodes.com)
Insurance company telephone*	Insurance company telephone	Additional disease manifestation codes: <u>N/A</u>	
000001	000002		
Group #*	Group #	Co-administration Medication	
05/14/1057	01/01/104.0	- oo-daministration Medication	
Policyholder's DOB*: <u>05/16/1957</u> (MM/DD/YYYY)	Policyholder's DOB: 01/01/1960 (MM/DD/YYYY)	â	â
IPA/Medical Group	877-555-1234	Is there an immunomodulator prescribed?	Yes 🔾 No If yes, please indicate below:
PA/Medical group name	IPA/Medical group telephone	methotrexate O Other	
Reverification request			
Revenication request		Prescription Information (Requi	ired for specialty pharmacy benefit)
Patient is uninsured to my knowledge		rescription mornation (*Indic	cates a required field)
			fan internet an informan a complete a la
Infusion Facility (*Indicates a requ	uired field)	Dose: KRTSTEXXA" (pegioticase) injection, 8 mg/mL	, for intravenous infusion every two weeks
		Vial quantity*: 2 Refills*: 6	., for intravenous infusion every two weeks
Do you have a preferred infusion facility?*	Yes O No If yes, please fill out the preferred infusion	Vial quantity*: 2 Refills*: 6	_
Do you have a preferred infusion facility?* (acility information below. If no, Horizon By Your Side	Yes O No If yes, please fill out the preferred infusion will help identify a facility in close proximity to your patient.	Vial quantity*: <u>6</u> Allergies*:	., for intravenous infusion every two weeks or ☑ No known drug allergies (NKDA)
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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

AND METHEMOGLOBINEMIA

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

First name*	Last name*
Sex*: 🔘 Male 🔿 Female	Date of birth*: 05/16/1957

Patient Enrollment Form			z		1	
			NOTION		KRYSTEXXA pegloticase	
Complete all required fields, including prescrib to initiate patient enrollment process. For patient support and/or assistance obtaining call Horizon By Your Side at 1-877-633-9521.		Prescriber Informa	tion (*Indicates a	Prescriber		5
Patient Information (*Indicates a required fie	ld)	First name* 123 Medical Way		Last name*	X)	
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First name* Last no Sex*: Male Female Date o	ame* f birth*: <u>05/16/1957</u>	000000000 NPI #*	00-0000000 Tax ID #*		12121212 State license #*	
		johnprescriber@email.com				
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Patient Information (*		n			ase populate:	
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English	stephe	npatient@email.c	com			
Primary language	Email ac	ldress				
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555-123-1234 Primary telephone*	and/or alternate con		💽 Yes	🔘 No	le below.	
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	Consent to send tex	t message?	Yes	O No		
123 Main Street Address*					eeks	
Lake Forest	IL	6	0045		NKDA)	
City*	State*		P code*			
Jane Spouse	555-23				YSTEXXA or any	
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Please read page 2		Date*: 07/01/2022			e only; stamps not acceptable.	
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P-KRY-US-00253 07/22						

				your side	FRYSTEXXA ! * pegloticase
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555-123-1234 Consent to lear and/or alternat	ve voice message at patient te contact telephone? Yes No	Office contact name 555-123-0987 Office contact telephone* johnprescriber@email.co	m	555-123-4567 Fax*	
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Patient Information	(*Indicates a required field	d)			ase populate:
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rst name*	Last na				
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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.



Anaphy

- \checkmark 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"

First name*	Last name*
Sex*: 🔘 Male 🔿 Female	Date of birth*: 05/16/1957

Insurance Provider 1 Primary insurance*	
1234567	
Policy #*	
Stephen Patient	
Policyholder's first and last name*	
800-123-4567	
Insurance company telephone*	
000001	
Group #*	
Policyholder's DOB*: 05/16/1957	

			Voui Youi side	KRYSTEXXA
Complete all required fields, including prescriber's signature an to initiate patient enrollment process. For patient support and/or assistance obtaining patient signatu call Horizon By Your Side at 1-877-633-9521.		Prescriber Informati John First name*	ON (*Indicates a required fie Prescribe Last name	
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555:123:1234 Consent to leave voice message at patier Primary telephone* and/or alternate contact telephone?	nt 💽 Yes 🔿 No	Office contact name 555-123-0987 Office contact telephone*	555-123-4 Fax*	567
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Stephen Patient	Jane S			es.com)
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tephen Patient ted full name see Important Safety Information on page 2 and se	e Full	I certify that the above th uncontrolled gout.*	erapy is medically necessary f	or the treatment of documented
P-KRY-US-00253 07/22		The above signature grants	permission to share records with	the referring office and infusion facility. Page 1 of 2

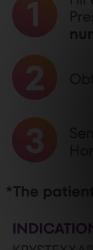
Anaphylaxis may occur with any infusion, including a first infusion, and generally i

- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for a
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels inc 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.



for KRYSTEXXA*:



B 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

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

First name*	Last name*	
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555-123-1234 Primary telephone*	Consent to leave voice message at patient and/or alternate contact telephone? Ye	
O Home O Cell 123 Main Street	Consent to send text message? Ye	

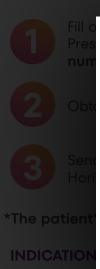
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nfusion	Center

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Facility address*	
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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

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 th infusion. Delayed hypersensitivity reactions have also been reported.
- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for a period after administration of KRYSTEXXA.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels include 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.

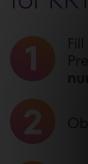
Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

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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

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

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

Once complete, submit by email GoutHBYS@horizon		pr		HORIZON Jour side	KRYSTEXXA pegloticase
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Sex*: 🔘 Male 🔿 Female	Date of birth*: 05/16/1957		NPI #* Tax	ID #*	State license #*
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			I certify that the above therapy is	s medically necessary for the	e treatment of documented
see Important Safety Info	rmation on page 2 and see a Boxed Warning, at KRYST		uncontrolled gout.* The above signature grants permissi		ferring office and infusion facility.
P-KRY-US-00253 07/22					



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

Diagnosis 6

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

 Add additional disease manifestation codes, if applicable

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
- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for a period after administration of KRYSTEXXA.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels incr 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 Once complete, submit email GoutHBYS@hori:			KRYSTEXXA your side
to initiate patient enrollment pr	stance obtaining patient signature,	Prescriber Information (*)	ndicates a required field) Prescriber
Patient Information (*Ind	icates a required field)	First name* 123 Medical Way Address*	Last name*
Stephen First name* Sex*: Male Female English Primary language 555-123-1234 Primary telephone*	Patient Last name* Date of birth*: 05/16/1957 (MM/DD/YYYY) stephenpatient@email.com Email address Consent to leave voice message at patient and/or alternate contact telephone?	NPI #* Tax I Memorial Hospital Clinic/hospital affiliation Jenny Assistant Office contact name	L 00016 State* ZIP code* 0000000 12121212 D #* State license #* 555-123-4567 Fax*
Address*	Consent to send text message? Yes O No	johnprescriber@email.com Email address* Preferred communication: O Telephone Referring healthcare provider: Was this p	Email Prescriber specialty*: <u>Rheumatology</u>
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Patient Enrollment Form Once complete, submit by fax email GoutHBYS@horizonthe			Vour side KRYSTEXXA peglolicase	
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Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:



Co-administration Medication

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

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
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- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for a period after administration of KRYSTEXXA.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels incre 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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Complete all required fields, including to initiate patient enrollment process For patient support and/or assistance call Horizon By Your Side at 1-877-633	e obtaining patient signature,	Prescriber Information ("Indica	tes a required field)
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First name* Sex*: Male Female English Primary language	Last name* Date of birth*: 05/16/1957 (MM/DD/YYYY) stephenpatient@email.com Email address	City* 00-0000 NPI #* 00-0000 Memorial Hospital Clinic/hospital difflication Jenny Assistant Jenny Assistant	State* ZIP code* 000 12121212 State license #*
555-123-1234 and/o Primary telephone*	ant to leave voice message at patient r alternate contact telephone? Yes No ant to send text message? Yes No	Office contact telephone* johnprescriber@email.com Email address*	555-123-4567 Fax*
Lake Forest City* Jane Spouse Alternate contact name	IL 60045 State* ZIP code* 555-234-5678 Alternate contact telephone tes a required field) (Please include front and	Referring healthcare provider: Was this patient referred to you by another HCP?	
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Three easy steps to initiate the patient enrollment process for KRYSTEXXA*:



8 Prescription Information

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

IMPORTANT SAFETY INFORMATION

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

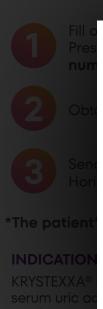
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- KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage
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Please see additional Important Safety Information on page 11 and click for Full Prescribing Information, including Boxed Warning.

First name*	Last name*	
Sex*: 🔘 Male 🔿 Female	Date of birth*: <u>05/16/1957</u>	
	Consent to leave voice message at patient and/or alternate contact telephone? • Yes	
Primary telephone*	ana/or alternate contact telephone? Units	

Patient Enrollment Form Once complete, submit by fax 1-877-633-9522 or email GoutHBYS@horizontherapeutics.com		Noziu your side	STEXXA peglolicase
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.	Prescriber Information ("India John First name"	cates a required field) Prescriber Last name*	5
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see Important Safety Information on page 2 and see Full Scribing Information, including Boxed Warning, at KRYSTEXXAhcp.com.	uncontrolled gout.* The above signature grants permission to		
P-KRY-US-00253 07/22			





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

9

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

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

Stephen	Patient	
First name*	Last name*	
Sex*: 🔘 Male 🔵 Female	Date of birth*: 05/16/1	957
	stephenpatient@em	
Primary language	Email address	
	Consent to leave voice message at p	
Primary telephone*	and/or alternate contact telephone?	Yes
O Home 🔘 Cell		🔘 Yes
Address*		



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55-123-1234 imary telephone*	Consent to leave voice n and/or alternate contact	t telephone?	• Yes • No	Office contact name <u>555-123-0987</u> Office contact telephone* johnprescriber@email.com		555-123-4567 Fax*	
Home O Cell 23 Main Street ddress*			• Yes • No	Email address* Preferred communication:	Telephone 🔘 E	mail Prescriber sp	ecialty*: Rheumatology
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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.

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.

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.

