Patient Enrollment Form

Please fax the completed form with a copy of the front and back of the patient's insurance card to 1-877-633-9522.

(Physician signature required. Patient signature required only if requesting co-pay assistance or PAP.)

Krystexxa® CONNECT

1. PATIENT INFORMATION Please provide physical address; no P.O. boxes.	2. HEALTHCARE PROVIDER INFORMATION
Patient Name (last, first)	Provider Name (last, first)
Address	Facility Name
City State ZIP Code	Address
DOB SS # Gender: ☐ M ☐ F	City, State, ZIP Code
Phone # Alternate Phone #	Specialty NPI #
E-mail Legal US Resident? ☐ Y ☐ N	State License # Tax ID #
Applying for Co-Pay Program? ☐ Y ☐ N (Commercial insurance required - see Section 3)	Medicare Provider # Medicaid Provider #
Applying for Patient Assistance Program? ☐ Y ☐ N (Income verification required - see Section 4)	Medicare PIN # PTAN #
Caregiver	Office Contact
Caregiver Phone #	Phone # Fax #
Caregiver E-mail	Nurse Contact Fax #

INFUSION INFORMATION

Infusion Facility Name	NPI #/Tax ID # (need both)
How do you intend to supply the medication? ☐ Specialty Pharmacy _____ Buy and Bill ☐	Do you accept MasterCard? ☐ Y ☐ N
Address	Nursing Contact Name
City State ZIP Code	Nursing Contact Phone/E-mail

3. INSURANCE INFORMATION (If uninsured, check the "uninsured" box and leave the rest of the fields blank.)

☐ UNINSURED: not eligible for any public health insurance, including Medicare and Medicaid, or has been denied coverage by a third-party payer.

Primary Insurance	Secondary Insurance (if applicable)
Plan Name	Plan Name
Is this a Medicare Part D plan? ☐ Y ☐ N Is this a Medicaid plan? ☐ Y ☐ N	Is this a Medicare Part D plan? ☐ Y ☐ N Is this a Medicaid plan? ☐ Y ☐ N
Insurance Company Phone #	Insurance Company Phone #
Subscriber Name	Subscriber Name
Policy # Group #	Policy # Group #
Member ID BIN #	Member ID BIN #
Subscriber DOB Subscriber SS #	Subscriber DOB Subscriber SS #

4. PATIENT ASSISTANCE PROGRAM

(If patient is not interested/eligible for PAP, leave this section blank.)

Number of People in Household: Annual Household Income: $

You must submit proof of total household income. Accepted forms include most recently filed Federal Tax Forms (e.g., Form 1040), including supporting documents (W-2 or Social Security income [SSA 1099]). If you do not have proof of income, call 1-877-633-9521 to request Income Statement.

5. DIAGNOSIS AND THERAPY INFORMATION

Diagnosis:

ICD-9-CM Codes: ☐ 274.00 ☐ 274.02 ☐ 274.03

ICD-10-CM Codes: M1A.xxx0 - Chronic Gout without tophi
M1A.xxx1 - Chronic Gout with tophi
M10.xx - Gout

Please specify: _____

Treatment History

☐ Patient cannot take xanthine oxidase inhibitors due to contraindication or hypersensitivity reaction

☐ Patient's current oral treatment with xanthine oxidase inhibitors has failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled despite receiving maximum medically appropriate dose of oral ULT

My signature below certifies that the person named on this form is my patient and medications received from Crealta Pharmaceuticals LLC for any program are only for the use of the patient named on this form. I certify that the described therapy is medically necessary and my patient is being administered KRYSTEXXA® (pegloticase) in accordance with the labeled use of the product. I further certify that I have received the necessary authorization to release the referenced medical and/or other patient information relating to KRYSTEXXA therapy for the purpose of seeking KRYSTEXXA therapy and/or assisting in initiating or continuing KRYSTEXXA therapy. This medication will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning this medication to Medicare, Medicaid, or any public or private third-party reimbursement, or returned for credit. By signing, I also acknowledge that Crealta Pharmaceuticals LLC has the right to contact me regarding information related to reimbursement and to contact my patient directly to confirm receipt of medications. I understand that Crealta Pharmaceuticals LLC has the right to revise, change, or terminate this program at any time. I acknowledge that I shall not seek reimbursement for any medication dispensed through the Patient Assistance Program from any government program or third-party insurer. Finally, to the best of my knowledge, my patient meets Crealta Pharmaceuticals LLC's criteria for the services requested.

INDICATION
KRYSTEXXA (pegloticase) is a PEGylated uric acid specific enzyme indicated for the treatment of chronic gout in adult patients refractory to conventional therapy.

Gout refractory to conventional therapy occurs in 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.

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

CONTRAINDICATIONS
Glucose-6-phosphate dehydrogenase (G6PD) Deficiency: Before starting Krystexxa, confirm patients are not G6PD deficient. Patients at higher risk for G6PD deficiency (e.g., those of African and Mediterranean ancestry) should be screened due to the risk of hemolysis and methemoglobinemia, however any patient could be affected.

Please see Important Safety Information and accompanying Full Prescribing Information, including Boxed Warning, located on www.krystexxa.com.

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS

- **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. However, delayed-type hypersensitivity reactions have also been reported.**
- **KRYSTEXXA should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.**
- **Patients should be premedicated with antihistamines and corticosteroids.**
- **Patients should be closely monitored for an appropriate period of time for anaphylaxis after administration of KRYSTEXXA.**
- **Monitor serum uric acid levels prior to infusions and consider discontinuing treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.**

[redacted] Healthcare Provider Signature: Date:

[redacted]

By signing the following form, I am authorizing my enrollment in the KRYSTEXXA Connect Co-Pay Reduction Program and the comprehensive programs that are associated with KRYSTEXXA Connect. KRYSTEXXA Connect offers reimbursement support services, including answers for general insurance questions, benefits investigations, searches for alternative coverage, assistance with prior authorizations and appeals, and a Patient Assistance Program for qualified individuals. The KRYSTEXXA Connect Clinical Support Program is designed to provide patients with reminder calls from a Case Manager, the opportunity to track the progress of your therapy, and assistance with other questions you may have about KRYSTEXXA. In order for me to obtain services under the KRYSTEXXA Connect Programs ("Programs"), I understand that Crealta Pharmaceuticals LLC ("Crealta"), Rx Crossroads, LLC (the "Program Administrator"), Advanced Care Scripts, Inc. (the product "Supplier"), and its third-party affiliates and authorized agents (collectively "Company") will need to use and disclose information and records about me, my health insurance coverage, and my medical diagnosis and treatment. I authorize my healthcare provider ("Providers") and insurance company ("Insurers") to give Company such information. I understand that once Providers and Insurers give Company information based on this Authorization, this information may no longer be protected by federal or state privacy laws and, as a result, may be further disclosed. However, Company will use such information solely (i) to facilitate my participation in the Programs; (ii) to administer, assess, and improve the Programs; (iii) to account for my withdrawal if I decide to stop participating in the Programs; (iv) to track general use of KRYSTEXXA; and (v) as required by law. I understand that I am voluntarily signing and returning this Authorization to be able to take part in the Programs. I understand that Crealta may contact me by telephone or postal mail in connection with my enrollment in these Programs. I also understand that Crealta may use my name and contact information for market and outcomes research and to improve the information that Crealta provides to patients who are being treated with KRYSTEXXA. If I do not sign and return this Authorization, my decision will not affect my ability to obtain treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits. However, Company will not be able to verify my insurance coverage for KRYSTEXXA and I will not have access to the Programs. I also understand that I can cancel this Authorization at any time by writing to KRYSTEXXA Connect, P.O. Box 5667, Louisville, KY 40255-0667. Termination shall be effective upon Company's receipt of such notification; however, I cannot cancel actions already taken when relying on the signed Authorization. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me.

[redacted] Patient Signature: _____ Date: _____

crēalta pharmaceuticals®

KRY-P-1026.a (09/15)

Krystexxa® (pegloticase) Injection, 8mg/mL, for Intravenous Infusion