

Welcome to Horizon Patient Services!

To get started, fill out Section 1, followed by the other sections as needed.

- 1 Patient Services:** This section is required and includes the option to have a dedicated Patient Access Manager (PAM) provide financial and medical support, including co-pay assistance, to your patient throughout treatment.
- 2 Benefits Investigation:** To have Horizon Patient Services conduct a benefits investigation for your patient, **please also complete this section.**
- 3 Insurance Authorization Support:** Complete this section and send clinical documentation to receive insurance authorization support (recommended for buy and bill, prior authorization, and predetermination support, including pre/postinfusion denials). **Please also complete page 3.**

1 Patient Services

PATIENT INFORMATION (Please provide physical address; no PO boxes.)

Name (First, MI, Last): _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____ Email: _____
 Gender: Male Female Primary Language: _____
 Date of Birth: _____ Height: _____ Weight: _____
 Alternate Contact: _____ Relationship: _____
 Phone: _____ Email: _____

UNINSURED: Patient is ineligible for any health insurance, including Medicare and Medicaid, or has been denied by third-party payer. Please evaluate them for Patient Assistance Program. (Proof of income is required.)

Primary Insurance (Please include a copy of front and back of insurance card.)

Plan Name: _____ Phone: _____
 ID Number: _____ Group Number: _____

Secondary Insurance

Plan Name: _____ Phone: _____
 ID Number: _____ Group Number: _____

Patient:
 I acknowledge that I have read and understand the Patient Authorization on page 2 and agree to the terms.

SIGNATURE: _____ Date: _____

PHYSICIAN INFORMATION

Name (First, MI, Last): _____
 Practice Name: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____
 Referring Physician: _____

Specialty: _____
 Office Contact: _____ Office Phone: _____
 Email: _____
 License #: _____ NPI #: _____
 Tax ID #: _____
 Specialty: _____

Physician:
 I acknowledge that I have read and understand the Physician Certification on page 2 and agree to the terms.

If prescription is written in consultation with another specialist, please complete the following:

Rheumatologist _____
 Rheumatologist's Name Consultation Date
 Nephrologist _____
 Nephrologist's Name Consultation Date

SIGNATURE: _____ Date: _____

(Required)

2 Benefits Investigation (Please fill in the following information.)

SITE OF CARE

Yes No **Need assistance identifying facility per payer guidance?**

↳ If no, please continue to the following questions.

Preferred Facility: _____

Yes No **Is this facility a hospital outpatient facility?**

NPI #: _____ (if in-office) Tax ID #: _____ (if site of care)

Medication Acquisition Route: Buy and Bill Specialty Pharmacy

Yes No **Does the facility accept Mastercard®?**

Send Summary of Benefits to the SOC if different from Physician Information above:

Contact Name: _____

Phone: _____ Fax: _____

DIAGNOSIS AND CONTRAINDICATIONS

Primary Diagnosis: M1A. – Chronic Gout*

*Use Chronic Gout ICD-10 Codes Wheel in Reimbursement Kit or see the full list of the most current codes at ChronicGoutCodes.com

†Asymptomatic hyperuricemia is defined as elevated uric acid level (>6.8 mg/dL) in patients who have never exhibited signs or symptoms of gout (eg, gout flare, tophi). G6PD, glucose-6-phosphate dehydrogenase.

Yes No **Does the patient have a diagnosis of asymptomatic hyperuricemia† or a deficiency in G6PD?**

↳ If yes, patient is not a candidate for KRYSTEXXA.

PATIENT AUTHORIZATION (Please read and provide signature in Patient Information section on page 1.)

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, “Horizon”), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, “Horizon Patient Services”) for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon Patient Services and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon Patient Services for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon Patient Services otherwise as required or permitted by law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the program.

I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon Patient Services, 150 South Saunders Rd, Lake Forest, IL 60045, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

PHYSICIAN CERTIFICATION (Please read and provide signature in Physician Information section on page 1.)

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I understand that Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, “Horizon”) will use this information to administer the Horizon Patient Services™ program (the “Program”), which provides assistance to patients in verifying insurance coverage for KRYSTEXXA or assistance in initiating and continuing KRYSTEXXA as prescribed. I certify that the described therapy is medically necessary and my patient is being administered KRYSTEXXA® (pegloticase) Injection, 8 mg/mL, for Intravenous Infusion in accordance with the labeled use of the product. By my signature, I also certify that my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share Protected Health Information with Horizon for purposes of the Program. I appoint the Program, on my behalf, to proceed with services offered and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I further certify that I have obtained the patient's authorization to release the above information and such other information as may be required for RxC Acquisition Company d/b/a RxCrossroads, or another party, acting on behalf of Horizon, to assist in obtaining coverage for KRYSTEXXA® and to assist in initiating or continuing therapy. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use KRYSTEXXA® or any other Horizon product or service, for any other person, (b) my decision to prescribe KRYSTEXXA® was based solely on my professional determination of medical necessity, and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice.

By filling out this form, your Chronic Gout patient is automatically enrolled into the Patient Access Manager Program.

The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Horizon makes no representation or guarantee concerning coverage or reimbursement for any item or service.

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.

By filling out this form, your patient is automatically enrolled into Horizon Patient Services.

For Patient: _____ DOB: _____

3 Insurance Authorization Support (Please fill in the following information.)

SELECT SERVICE(S):

Prior Authorization (PA) or Predetermination

A predetermination is recommended if your practice is planning to buy and bill KRYSTEXXA.

Reconsideration or Appeal

DOSE: 8 mg every 2 weeks, NDC: 75987-0080-10 J Code: J2507

Is this for initiation or continuation of therapy?

Initiation:

Date of 1st Infusion: ____/____/____ Duration of Treatment: _____
(mm/dd/yyyy)

Continuation:

Original Start Date: ____/____/____ Last Infusion Date: ____/____/____
(mm/dd/yyyy) (mm/dd/yyyy)

CURRENT SYMPTOMS

What is the patient's most recent sUA level and date obtained?

____ mg/dL, date obtained: ____/____/____
(mm/dd/yyyy)

Yes No Is there evidence of a tophus?

_____ → **If yes**, how many: _____

Yes No Is there evidence of gouty arthritis?
(tender and swollen or lesioned joints)

_____ → **If yes**, how many joints are impacted? _____

Yes No Has the patient experienced functional impairment?

_____ → **If yes**, please describe: _____

Yes No Has the patient experienced 3 or more flares in
the past 18 months?

_____ → **If no**, how many flares has the patient experienced
in the past 18 months? _____

_____ → **If yes**, please provide most recent dates: ____/____/____, ____/____/____, ____/____/____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

GFR, glomerular filtration rate; sUA, serum uric acid.

Yes No Does patient have kidney dysfunction?

_____ → **If yes**, GFR: _____ Serum creatinine: _____

Yes No Has the patient undertaken appropriate lifestyle modifications?

_____ → **If yes**, please check all that apply:

- Discontinuing or changing medications that are known to precipitate gout attacks
- Implementing diet changes (consume low-purine diet, reduce refined carbohydrates, limit meats, increase vegetables and fruit)
- Decreasing alcohol consumption
- Limiting drinks rich in fructose
- Unknown
- Other: _____

ORAL URATE-LOWERING TREATMENT HISTORY

Treatment	Patient at Max Medically Appropriate Dose	Max Dose	Start Date	End Date	sUA at End of Treatment	Explain Outcome or Specify Contraindication	Patient is Contraindicated
Allopurinol							<input type="checkbox"/>
Febuxostat							<input type="checkbox"/>
Probenecid/ Lesinurad/ _____ (circle or write in uricosuric)							<input type="checkbox"/>

Yes No Will oral urate-lowering treatments be discontinued before starting KRYSTEXXA?
Patients should discontinue oral urate-lowering treatments before starting KRYSTEXXA.

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge.

Physician:

SIGNATURE: _____ Date: _____

(Required)

Please read Physician Authorization on page 2.

INDICATION AND IMPORTANT SAFETY INFORMATION

INDICATIONS AND USAGE

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.

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

IMPORTANT SAFETY INFORMATION

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.

The risk of anaphylaxis and infusion reactions is higher in patients who have lost therapeutic response.

Concomitant use of KRYSTEXXA and oral urate-lowering agents may blunt the rise of sUA levels. Patients should discontinue oral urate-lowering agents and not institute therapy with oral urate-lowering agents while taking KRYSTEXXA.

In the event of anaphylaxis or infusion reaction, the infusion should be slowed, or stopped and restarted at a slower rate.

Inform patients of the symptoms and signs of anaphylaxis, and instruct them to seek immediate medical care should anaphylaxis occur after discharge from the healthcare setting.

CONTRAINDICATIONS: G6PD DEFICIENCY ASSOCIATED HEMOLYSIS AND METHEMOGLOBINEMIA

Screen patients for G6PD deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. Do not administer KRYSTEXXA to these patients.

GOUT FLARES

An increase in gout flares is frequently observed upon initiation of anti-hyperuricemic therapy, including treatment with KRYSTEXXA. If a gout flare occurs during treatment, KRYSTEXXA need not be discontinued. 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 studied in patients with congestive heart failure, but some patients in the clinical trials experienced exacerbation. Exercise caution when using KRYSTEXXA in patients who have congestive heart failure and monitor patients closely following infusion.

ADVERSE REACTIONS

The most commonly reported adverse reactions in clinical trials with KRYSTEXXA are gout flares, infusion reactions, nausea, contusion or ecchymosis, nasopharyngitis, constipation, chest pain, anaphylaxis and vomiting.

Please click for [Full Prescribing Information](#), including [Boxed Warning](#), and [Medication Guide](#).