5. DIAGNOSIS AND THERAPY INFORMATION

Diagnosis:

ICD-9-CM Code: ☐ 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 Horizon Pharma plc 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) Injection, 8 mg/mL, for IV Infusion 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 Horizon Pharma plc 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 Horizon Pharma plc 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 Horizon Pharma plc'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, and Medication Guide, also available at 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 Horizon Pharma plc ("Horizon Pharma"), 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 Horizon Pharma may contact me in connection with my enrollment in these Programs. I also understand that Horizon Pharma may use my name and contact information for market and outcomes research and to improve the information that Horizon Pharma 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: _____

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