# KRYSTEXXA (pegloticase) Ready-to-Use (RTU) Vial PATIENT ENROLLMENT FORM

**Once complete, submit pages 1-4 by fax 1-877-633-9522 or email GoutABYS@amgen.com**

**Initiate the patient enrollment process by completing ALL REQUIRED FIELDS indicated by *.**
**For patient support and/or assistance obtaining patient signature, call Amgen By Your Side at 1-877-633-9521.**

USA-400-80443 06/25

## PATIENT INFORMATION

**First name*** _____ **Last name*** _____

Gender: ○ Male ○ Female **Date of birth*:** ___ /___ /_____ (MM/DD/YYYY)

**Email address*** _____ Primary language _____

_____ ○ Primary **Mobile phone*** _____ ○ Primary **Home phone***

**Address*** _____

**City*** _____ **State*** _____ **Zip code*** _____

Alternate contact name _____ Alternate contact phone _____

## DIAGNOSIS
**Required for benefits investigation**

**Primary diagnosis code*: M1A.** _____ **— Chronic gout**

See full list of codes at **ChronicGoutCodes.com**.

Additional disease manifestation codes: _____

**Medications tried/previous therapy*:** _____

## CO-ADMINISTRATION MEDICATION

Is there an immunomodulator prescribed? ○ Yes ○ No

If yes, please indicate: ○ methotrexate ○ Other

## INSURANCE INFORMATION
**Please include front and back copies of insurance card[s] with this form**

**Primary insurance*** _____ Secondary insurance _____

**Policy #*** _____ Policy # _____

**Policyholder's first and last name*** _____ Policyholder's first and last name _____

**Insurance company phone*** _____ Insurance company phone _____

**Group #*** _____ Group # _____

**Policyholder's Date of birth*:** ___ /___ /_____ (MM/DD/YYYY) Policyholder's Date of birth: ___ /___ /_____ (MM/DD/YYYY)

IPA/Medical group name _____ IPA/Medical group name _____

○ Reverification request ○ Patient is uninsured to my knowledge.

## PRESCRIBER INFORMATION

**First name*** _____ **Last name*** _____

**Address*** _____

**City*** _____ **State*** _____ **Zip code*** _____

**NPI #*** _____ **State license #*** _____ **Tax ID #*** _____

Clinic/hospital affiliation _____

**Office contact name*** _____ **Office contact phone*** _____

**Email address*** _____ **Fax number*** _____

**Prescriber specialty*:** _____

Preferred communication: ○ Phone ○ Email

## CO-MANAGING/REFERRING HCP
**Complete if patient was sent to you by another healthcare provider. They will be part of the patient's care team.**

First name _____ Last name _____

Specialty _____ Phone _____

Address _____

City _____ State _____ Zip code _____

## PREFERRED INFUSION FACILITY
**If none, Amgen By Your Side can provide options.**

○ The infusion facility is the same as the prescribing office

Facility name _____ Address _____

City _____ State _____ Zip code _____

Phone _____ Fax number _____

Facility NPI # _____ Tax ID # _____

**Complete signatures and prescription information on next page**



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## PATIENT CONSENT AND AUTHORIZATION (Required - please see language on pages 3-4.)



You must read the Consent to Health Data Processing on page 4 and then select one of the below responses.

**Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to enroll in Amgen By Your Side**

- ○ I **consent** to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 4.
- ○ I **do not consent** to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 4.

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information (pages 3-4), that I am legally authorized to consent, and that I am providing my consent as the patient or the patient's legal representative for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization for Use and Disclosure of Protected Health Information.

**Patient name***

Name of Legal Representative (if needed)

**Signature of Patient (or Legal Representative)***

**Date*** (MM/DD/YYYY)

## PRESCRIPTION (Required)

**Patient first name***

**Patient last name***

**Date of Birth*** (MM/DD/YYYY)

Dose: KRYSTEXXA® (pegloticase) injection, 8 mg/50 mL, for intravenous infusion every two weeks for no less than 120 minutes

**Vial quantity*:** _____ **Refills*:** _____ **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:** Do not administer KRYSTEXXA as an intravenous push or bolus. KRYSTEXXA should only be administered by intravenous infusion. An infusion pump may be used for the Ready-to-Use vial.

**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.**

**Signature below indicates prescription authorization and prescriber certification.**

**Prescriber signature (Dispense as written)***

Written or e-signature only; stamps not acceptable.

Prescriber signature (substitutions allowed)

**Date*** (MM/DD/YYYY)

**Prescriber Certification:** I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered KRYSTEXXA (pegloticase), for injection, 8mg/50 mL, for intravenous infusion in accordance with the labeled use of the product. I represent that my patient has requested and authorized the disclosure of their personal information to Amgen, Inc. and its affiliates and their respective employees or agents (collectively, "Amgen") for Amgen to administer the Amgen By Your Side program (the "Program"), which provides patient-focused support, including providing logistical and non-medical treatment support for KRYSTEXXA, as prescribed, and educating about the insurance process. I further represent that I have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information to administer the Program; 2) Amgen will then disclose the patient's personal information to the patient's insurer(s) for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-844-469-4297 or visiting www.amgen.com/DataSubjectRights, but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at www.amgen.com/privacy. I authorize Amgen to transmit this prescription on my behalf to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under appliable law. 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 Amgen 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 Amgen may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Amgen makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Amgen expects the prescriber to coordinate with Amgen By Your Side to provide, to the best of the prescriber's ability, in-network infusion services and work with Amgen By Your Side to effectively communicate both in-network and out-of-network choices and the corresponding financial obligations of the patient connected to each choice. Should the prescriber knowingly perform out-of-network services without the knowledge and consent of the patient, the prescriber cannot balance bill the patient for the out-of-network services.
State requirements: I certify that the prescription I am submitting as part of this Patient Enrollment Form complies with my state's prescription requirements (e.g., e-prescribing, state-specific prescription form, fax language). I understand that noncompliance with my state's specific prescription requirements will result in outreach to me to obtain a compliant prescription.
By filling out and signing this form, the enrollment process in Amgen By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Amgen By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Amgen will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

## Uses and Disclosure of Protected Health Information

I authorize Amgen and its data processors (collectively, "Amgen") to collect, use, and disclose my protected health information for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in the Amgen By Your Side program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, patient access liaison services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- To improve, develop, and evaluate Amgen's products, services, materials and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including my protected health information. I understand that my protected health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor (each, a "Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my protected health information to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my protected health information and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example, medication reminder programs and other patient support services).

## Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to disclose it to Amgen. I also understand I am authorizing my personal information, including my protected health information, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to disclose my protected health information for the earlier of five (5) years or until my participation in the Amgen By Your Side program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at 1-844-469-4297 or by writing to Amgen By Your Side, 1 Horizon Way, Deerfield, IL 60015. If I cancel this Authorization, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my protected health information to Amgen in reliance on this Authorization on an on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

## No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect my protected health information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

## Information Received from Health Care Providers

I understand that once my protected health information has been disclosed to Amgen, federal privacy laws may no longer apply and may no longer protect it from further disclosure, and that Amgen may disclose my protected health information to its data processors, contractors, and business partners for its business purposes. Amgen agrees, however, to protect my protected health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

# U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA FOR AMGEN BY YOUR SIDE

Please read and provide response in Patient Consent and Authorization section on page 2

I consent to Amgen processing my Health Data for the following purposes:

- To enroll me and manage my participation in the Amgen By Your Side program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, patient access liaison support, disease management support), and to manage Amgen's products, services, and programs related to my condition or treatment.

### Amgen uses the following when it administers the Amgen By Your Side program:

- Health Data – my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to processing is required for me to participate in the Amgen By Your Side program. I also understand that Amgen will not sell my Health Data to third parties, but Amgen may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen By Your Side program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. Mobile Terms & Conditions can be found at AmgenByYourSide.com/mobile-terms-and-conditions. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the Amgen By Your Side program. Finally, I understand that I may withdraw my consent to processing my Health Data for the above purposes at any time using one of the methods listed in the Additional Disclosures section below and that if I withdraw my consent, I will no longer be able to participate in the Amgen By Your Side program.

## Additional Disclosures

I understand that participation in the Amgen By Your Side program is an optional service at no cost to me. The consent above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent above or to withdraw my consent to collection, processing, and/or disclosure of my Health Data for any of the above purposes to which I have consented, I can contact Amgen by visiting www.amgen.com/DataSubjectRights or calling 1-844-469-4297. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at http://www.amgen.com/privacy


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PURE INFUSION SM

# KRYSTEXXA (pegloticase)

AIC Order Form

To ensure swift processing of your order, please complete all fields.

## PATIENT INFORMATION

Patient Name:_____ Sex:_____ DOB:_____

Address:_____ City:_____ State: _____ Zip:_____

Phone:_____ Alt. Phone:_____ Height:_____ Weight: _____kg

Allergies:_____ ☐ No Known Drug Allergies

Emergency Contact:_____ Emergency Contact Phone:_____

Alternate Contact:_____ Alternate Contact Phone:_____

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Therapy change Last Infusion Date (if applicable):_____

Is the patient pregnant, nursing or planning a pregnancy? ☐ Yes ☐ No Does the patient need interpreter services? ☐ Yes ☐ No

## PRESCRIBER INFORMATION

Ref. Coordinator Name:_____ Ref. Coordinator Phone:_____

Ref. Coordinator Email:_____ Practice Name:_____

Prescriber's Name:_____ NPI:_____ Tax ID:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Phone:_____ Fax:_____

## PREFERRED PURE INFUSION LOCATION

City, State:_____

## DIAGNOSIS (ICD-10 Codes)

☐ M1A.9XX0 Chronic gout without tophus (tophi) ☐ M1A.9XX1 Chronic gout with tophus (tophi)

☐ Other: _____

## MEDICATION ORDER

☐ Krystexxa® (pegloticase) ☐ 8mg IV every 2 weeks

*Duration: 1 year of treatment unless indicated otherwise*

## PRE-MEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500 mg PO ☐ 650 mg PO ☐ 1000 mg PO

☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV

☐ cetirizine (Zyrtec) ☐ 10 mg PO OR ☐ loratadine (Claritin) ☐ 10 mg PO

☐ methylprednisolone (Solu-Medrol) ☐ 40 mg IV ☐ 125 mg IV OR ☐ hydrocortisone (Solu-Cortef) ☐ 100 mg IV

☐ Other:_____ ☐ No pre-medications ☐ All pre-medications are PRN

## LAB ORDERS

☐ Required pre-treatment labs to be completed prior to infusion/injection. If lab results are unavailable or outside required timeframes, Pure may obtain required labs.

☐ Other:_____

*If patient has port, please complete port order form.*

## REQUIRED DOCUMENTATION (submit copies of the following with this order form)

☐ Insurance card (front & back) ☐ Current Medications ☐ History/Progress Notes to Support Diagnosis

☐ Uric Acid within 72 hours of each dose ☐ G6PD

# KRYSTEXXA (pegloticase)

AIC Order Form

To ensure swift processing of your order, please complete all fields.

## PATIENT INFORMATION

Patient Name:_____ DOB:_____

## INFUSION REACTION PROTOCOL

☐ Pure Infusion Reaction Protocol

☐ Other Reaction Protocol (please send with order)

_____ _____ _____

Prescriber's Signature | Date | Time