Please fax both pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to <u>MyAccredoPatients.com</u> to log in or get started.

Prescription & Enrollment Form Krystexxa[®] (pegloticase)



Four simple steps to submit your referral.

1 Patient Information	
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Please provide copies of front and back of all medical and prescription insurance cards.

New patient C	Current patient				
Patient's first name _			Last name _		Middle initial
Male Female	Last 4 digits of SSN			Date of birth	
Street address					Apt #
City			State		Zip
Home phone		Cell phone		E-mail address	
Parent/guardian (if ap	oplicable)				
Alternate caregiver/co	ontact				
OK to leave messa	ge with alternate care	giver/contact			
Patient's primary lang	guage: English	Other If other, ple	ase specify		

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date		Time	[Date medication nee	ded	
Prescriber info: Pre	escriber's first nar	ne		Last i	name	
Prescriber's title			If NP	or PA, under direction	on of Dr	
Office phone		Fax		NPI #	License	#
Office contact and	title			Office of	contact e-mail	
Office street addre	SS					Suite #
-						Zip
					nplete information belo	
Infusion info: Infus	ion site name			Clinic/hospital at	ffiliation	
Site street address					\$	Suite #
City			State			Zip
Infusion clinic conta	ct name		Phone	e	E-mail	

3 Clinical Information

Primary ICD-10 code (REQUIRED):	Has the patient been treated previously for this condition? Yes	s No
Is patient currently on therapy? Yes No Please list al	I therapies tried/failed:	
Patient weight Date obtained		
NKDA Known drug allergies		
Concurrent meds		

Prescription & Enrollment Form: Krystexxa® (pegloticase)

Patient's first name	Last name	Middle initial	Date of birth	
Prescriber's first name	Last name	Phone	l	

4 Prescribing Information

Medication	Directions	Quantity/Refills
Krystexxa (pegloticase) 8mg/mL vial	8mg IV every 2 weeks	1-month supply. Refill x 1 year unless noted otherwise. 90-day supply. Refill x 1 year unless noted otherwise. Other Refills
Other		1-month supply. Refill x 1 year unless noted otherwise. 90-day supply. Refill x 1 year unless noted otherwise. Other Refills
	to strike through if not required) h as needles, syringes, sterile water, etc. and home medical equipment erapy as needed.	Send quantity sufficient for medication days supply

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN				
HERE	Date	Dispense as written	Date	Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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