



Krystexxa[®] (pegloticase)

Enrollment Form

For Blue Cross Blue Shield of Rhode Island Members

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Date: _____ Needs by Date (Please Specify): _____

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 SS #: _____
 Insurance ID: _____
 Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ UPIN: _____
 DEA #: _____ NPI #: _____
 Group or Hospital: _____
 Address: _____
 City, State Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____
 Contact Phone: _____

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card:	Name of Insurer: _____	ID#: _____	BIN: _____	PCN: _____	Group: _____
Primary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: Blue Cross Blue Shield of RI	Phone: _____	
Secondary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: _____	Phone: _____	

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of symptomatic chronic gout Yes No
- Please provide pre-treatment uric acid level _____
- Patient has tried and had an inadequate response to a 3-month trial of a xanthine oxidase (XO) inhibitor (ie, allopurinol or febuxostat) Yes No
 - If yes, was the maximum medically appropriate dose of a XO inhibitor given without adequate response Yes No
 - If no, is there a clinical reason for not completing a 3-month trial of a XO inhibitor? Yes No
 - Please document reason _____
- Uric acid levels will be monitored prior to each infusion Yes No
- If patient is currently receiving Krystexxa, has patient had 2 consecutive uric acid levels above 6 mg/dL Yes No
- Patient is at high risk for G6PD deficiency (eg, African or Mediterranean ancestry) Yes No
 - If yes, patient has been screened for G6PD deficiency Yes No
 - Please provide result of screening _____
- Krystexxa is given in a healthcare setting with access to emergency management for severe anaphylaxis and infusion reactions Yes No
- Patient will be premedicated with antihistamines and corticosteroids Yes No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Krystexxa [®] (pegloticase)				

PRODUCT SUBSTITUTION PERMITTED _____ (Date)

DISPENSE AS WRITTEN _____ (Date)

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