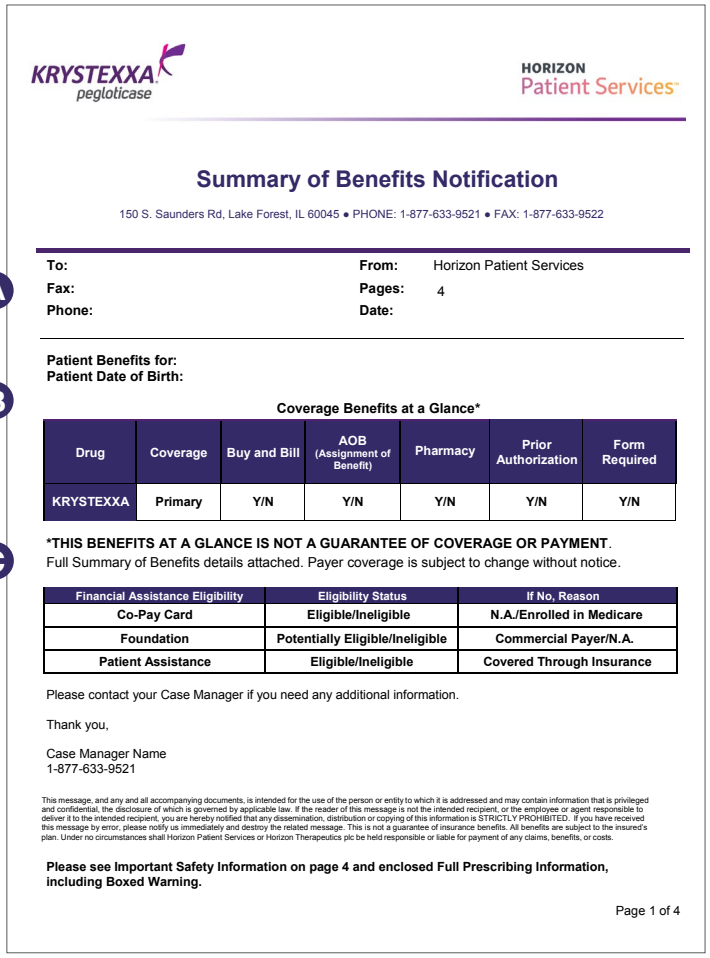
SUMMARY OF BENEFITS INSTRUCTION FORM

Once Horizon Patient Services verifies a patient's insurance coverage, you will receive a Summary of Benefits Notification within 2 business days. This example outlines the information you can expect to receive:

- **A** Patient contact information
- **B** Coverage benefits overview
- **C** Summary of financial assistance eligibility

For more information, please call **1-877-633-9521**, Monday to Friday, 8 AM to 8 PM ET, or visit us at **KRYSTEXXA.com/cost-savings**.



KRYSTEXXA pegloticase

HORIZON Patient Services™

Summary of Benefits Notification

150 S. Saunders Rd, Lake Forest, IL 60045 • PHONE: 1-877-633-9521 • FAX: 1-877-633-9522

A

To:		**From:**	Horizon Patient Services
Fax:		**Pages:**	4
Phone:		**Date:**	

B

Patient Benefits for:
Patient Date of Birth:

Coverage Benefits at a Glance*

Drug	Coverage	Buy and Bill	AOB (Assignment of Benefit)	Pharmacy	Prior Authorization	Form Required
KRYSTEXXA	Primary	Y/N	Y/N	Y/N	Y/N	Y/N

C

***THIS BENEFITS AT A GLANCE IS NOT A GUARANTEE OF COVERAGE OR PAYMENT.**
Full Summary of Benefits details attached. Payer coverage is subject to change without notice.

Financial Assistance Eligibility	Eligibility Status	If No, Reason
Co-Pay Card	Eligible/Ineligible	N.A./Enrolled in Medicare
Foundation	Potentially Eligible/Ineligible	Commercial Payer/N.A.
Patient Assistance	Eligible/Ineligible	Covered Through Insurance

Please contact your Case Manager if you need any additional information.

Thank you,

Case Manager Name
1-877-633-9521

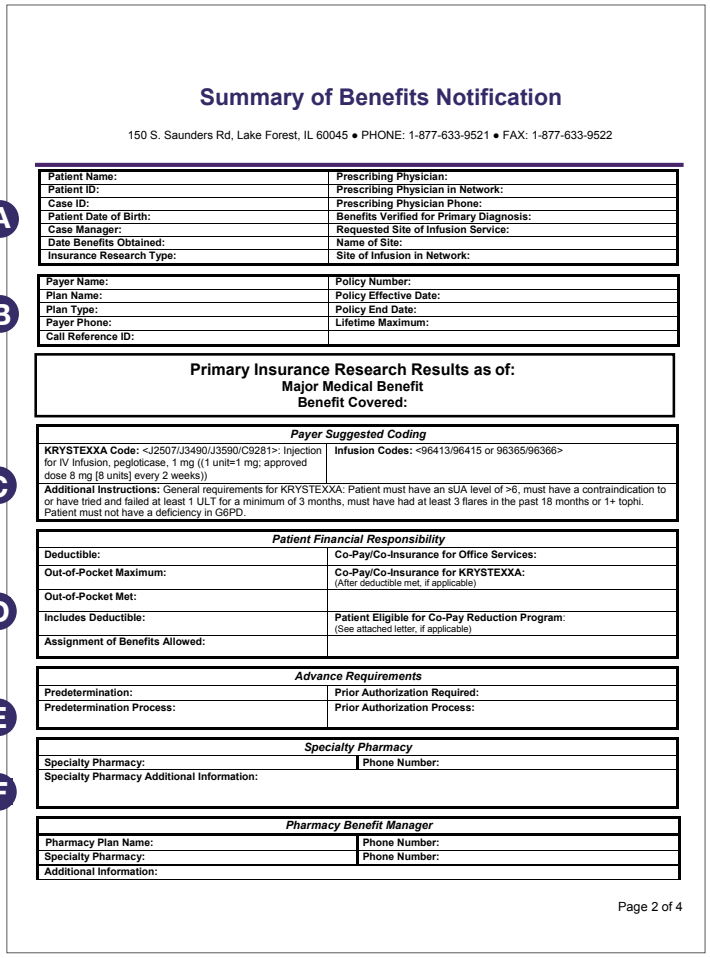
Please see Important Safety Information on page 4 and enclosed Full Prescribing Information, including Boxed Warning.

Page 1 of 4

SUMMARY OF BENEFITS INSTRUCTION FORM (cont'd)

- **A** Patient information
- **B** Payer and policy information
- **C** Coding requirements
- **D** Patient out-of-pocket costs
- **E** Predetermination and prior authorization requirements
- **F** Specialty pharmacy details, if applicable

For more information, please call **1-877-633-9521**, Monday to Friday, 8 AM to 8 PM ET, or visit us at **KRYSTEXXA.com/savings-support**.



Summary of Benefits Notification

150 S. Saunders Rd, Lake Forest, IL 60045 ● PHONE: 1-877-633-9521 ● FAX: 1-877-633-9522

A

Patient Name:	**Prescribing Physician:**
Patient ID:	**Prescribing Physician in Network:**
Case ID:	**Prescribing Physician Phone:**
Patient Date of Birth:	**Benefits Verified for Primary Diagnosis:**
Case Manager:	**Requested Site of Infusion Service:**
Date Benefits Obtained:	**Name of Site:**
Insurance Research Type:	**Site of Infusion in Network:**

B

Payer Name:	**Policy Number:**
Plan Name:	**Policy Effective Date:**
Plan Type:	**Policy End Date:**
Payer Phone:	**Lifetime Maximum:**
Call Reference ID:	

Primary Insurance Research Results as of:
Major Medical Benefit
Benefit Covered:

C

Payer Suggested Coding	
KRYSTEXXA Code: <J2507/J3490/J3590/C9281>: Injection for IV Infusion, pegloticase, 1 mg ((1 unit=1 mg; approved dose 8 mg [8 units] every 2 weeks))	**Infusion Codes:** <96413/96415 or 96365/96366>
Additional Instructions: General requirements for KRYSTEXXA: Patient must have an sUA level of >6, must have a contraindication to or have tried and failed at least 1 ULT for a minimum of 3 months, must have had at least 3 flares in the past 18 months or 1+ tophi. Patient must not have a deficiency in G6PD.	

D

Patient Financial Responsibility	
Deductible:	**Co-Pay/Co-Insurance for Office Services:**
Out-of-Pocket Maximum:	**Co-Pay/Co-Insurance for KRYSTEXXA:** (After deductible met, if applicable)
Out-of-Pocket Met:	
Includes Deductible:	**Patient Eligible for Co-Pay Reduction Program:** (See attached letter, if applicable)
Assignment of Benefits Allowed:	

E

Advance Requirements	
Predetermination:	**Prior Authorization Required:**
Predetermination Process:	**Prior Authorization Process:**

F

Specialty Pharmacy	
Specialty Pharmacy:	**Phone Number:**
Specialty Pharmacy Additional Information:	

Pharmacy Benefit Manager	
Pharmacy Plan Name:	**Phone Number:**
Specialty Pharmacy:	**Phone Number:**
Additional Information:	

Page 2 of 4

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 see Full Prescribing Information, including Boxed Warning.

KRYSTEXXA® pegloticase