TODT HILL PHARMACY

SPECIALTY PHARMACY

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GOUT

PATIENT INFORMATION

Please provide physical address, NO PO boxes

NAME (FIRST, ML, LAST) ____________________

ADDRESS ____________________

CITY ____________________ STATE ________ ZIP ____________

PHONE ____________________ EMAIL ____________________

GENDER ☐ MALE ☐ FEMALE PRIMARY LANGUAGE ____________________

DATE OF BIRTH ____________________ HEIGHT ____________ WEIGHT ________

ALTERNATE CONTACT ____________________ RELATIONSHIP ____________

PHONE ____________________ EMAIL ____________________

PATIENT SIGNATURE REQUIRED ____________________ DATE ______________

INSURANCE INFORMATION

Please attach front and back of all insurance cards

PLAN NAME ____________________ PHONE ____________________

IID NUMBER ____________________ GROUP NUMBER ____________________

SECONDARY INSURANCE

PLAN NAME ____________________ PHONE ____________________

IID NUMBER ____________________ GROUP NUMBER ____________________

PHYSICIAN INFORMATION

NAME (FIRST, ML, LAST) ____________________

PRACTICE NAME ____________________

ADDRESS ____________________

CITY ____________________ STATE ________ ZIP ____________

PHONE ____________________ EMAIL ____________________

REFERRING PHYSICIAN ____________________

SPECIALTY ____________________

OFFICE CONTACT ____________________ OFFICE PHONE ____________________

EMAIL ____________________

LICENCE # ____________________ NPI # ____________________

TAX ID # ____________________

SPECIALTY ____________________

PHYSICIAN SIGNATURE REQUIRED ____________________ DATE ______________

DIAGNOSIS AND CONTRAINDICATION

PRIMARY DIAGNOSIS ☐ M1A ☐ ☐ ☐ ☐ - CHRONIC GOUT*

* USE CHRONIC GOUT ICD -10 CODES WHEEL IN REIMBURSEMENT KIT OR SEE THE FULL LIST OF THE MOST CURRENT CODES AT www.CHRONICGOUTCODES.COM

☐ YES ☐ NO DOES THE PATIENT HAVE A DIAGNOSIS OF A SYMPTOMATIC HYPERURICEMIA OR A DEFICIENCY IN G6PD

IF YES, PATIENT IS NOT A CANDIDATE FOR KRYSTEXXA

†ASYMPTOMATIC HYPERURICEMIA IS DEFINED AS ELEVATED URIC ACID LEVEL (>6.8 mg/dl) IN PATIENTS WHO HAVE NEVER EXHIBITED SIGNS OR SYMPTOMS OF GOUT (EG, GOUT FLARE, TOPHI)
G6PD= GLUCOSE-6-PHOSPHATE DEHYDROGENASE

FOR PATIENT ____ DOB ______________________

DOSE: 8 mg EVERY 2 WEEKS, NDC: 75987-0080-10

IS THIS FOR INITIATION OR CONTINUATION OF THERAPY?

☐ INITIATION

DATE OF 1st INFUSION _____/_____/_____ (mm/dd/yyyy) DURATION of TREATMENT______________

☐ CONTINUATION

ORIGINAL START DATE _____/_____/_____ (mm/dd/yyyy) LAST INFUSION DATE _____/_____/_____ (mm/dd/yyyy)

CURRENT SYMPTOMS

WHAT IS THE PATIENT'S MOST RECENT SUA LEVEL AND DATE OBTAINED?
_______mg/dL, DATE OBTAINED: ______/______/______ (mm/dd/yyyy)

☐ YES ☐ NO IS THERE EVIDENCE OF A TOPHUS?
IF YES, HAW MANY: ___________

☐ YES ☐ NO IS THERE EVIDENCE OF GOUTY ARTHRITIS?
(TENDER AND SWOLLEN OR LESIONED JOINTS)
IF YES, HOW MANY JOINTS ARE IMPACTED? ____________________________

☐ YES ☐ NO HAS THE PATIENT EXPERIENCED FUNCTIONAL IMPAIRMENT?
IF YES, PLEASE DESCRIBE: ____
____

☐ YES ☐ NO HAS THE PATIENT EXPERIENCED 3 OR MORE FLARES IN THE PAST 18 MONTHS?
IF NO, HOW MANY FLARES HAS THE PATIENT EXPERIENCED IN THE PAST 18 MONTHS? ___________
IF YES, PLEASE PROVIDE MOST RECENT DATES _____/_____/_____ (mm/dd/yyyy), _____/_____/_____ (mm/dd/yyyy), _____/_____/_____ (mm/dd/yyyy)

SUN = SERUM URIC ACID

☐ YES ☐ NO DOES PATIENT HAVE KIDNEY DYSFUNCTION?
IF YES, GFR ____________________ SERUM CREATININE _____________________

☐ YES ☐ NO HAS THE PATIENT UNDERTAKEN APPROPRIATE LIFESTYLE MODIFICATIONS?
IF YES, PLEASE CHECK ALL THAT APPLY

- ☐ DISCONTINUING OR CHANGING MEDICATIONS THAT ARE KNOWN TO PRECIPITATE GOUT ATTACKS
- ☐ IMPLEMENTING DIET CHANGES (CONSUME LOW-PURINE DIET, REDUCE REFINED CARBOHYDRATES, LIMIT MEATS, INCREASE VEGETABLES AND FRUIT)
- ☐ DECREASING ALCOHOL CONSUMPTION
- ☐ LIMITING DRINKS RICH IN FRUCTOSE
- ☐ UNKNOWN
- ☐ OTHER

ORAL URATE LOWERING TREATMENT HISTORY

TREATMENT	PATIENT AT MAX MEDICALLY APPROPRIATE DOSE	MAX DOSE	START DATE	END DATE	sUA AT END OF TREATMENT	EXPLAIN OUTCOME OR SPECIFY CONTRAINDICATION	PATIENT IS CONTRAINDICATED
ALLOPURINOL							☐
FEBUXOSTAT							☐
PROBENECID/ LESINURAD/ _____________ (circle or write in uricosuric)							☐

☐ YES ☐ NO WILL ORAL URATE - LOWERING TREATMENTS BE DISCONTINUED BEFORE STARTING KRYSTEXXA?
PATIENTS SHOULD DISCONTINUE ORAL URATE-LOWERING TREATMENTS BEFORE STARTING KRYSTEXXA

I VERIFY THAT THE PATIENT AND HEALTHCARE PROVIDER INFORMATION ON THIS ENROLMENT FORM WAS COMPLETED BY ME OR AT MY DIRECTION AND THAT THE INFORMATION CONTAINED HEREIN IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

PHYSICIAN SIGNATURE REQUIRED ____ DATE ________________

PLEASE READ PHYSICIAN AUTHORIZATION ON PAGE 3