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|  <p>SENDERRA Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent & received via fax</i></p> | Gout Enrollment Form | Prescribing Practitioner: | NPI: | |
| | Physician Offices Call: 855-460-7928 | Supervising Physician: | NPI: | |
| | Fax: 888-777-5645 | Address: | Tax ID: | |
| | | Office: | Fax: | |
| | | Contact: | | |

| PATIENT INFORMATION | | | | | |
|---------------------|---|---|---------------------|------------|--|
| Name: | <input type="checkbox"/> M <input type="checkbox"/> F | DOB: ____/____/____ | SS#: ____-____-____ | | |
| Street: | City: | State: | Zip: | | |
| Tel: | Alt. Tel: | <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ | Wt.: _____ | Ht.: _____ | |

| PRESCRIPTION | | | |
|--|--|--|---------|
| <input type="checkbox"/> New <input type="checkbox"/> Refill | Ship by: ____/____/____ | SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____ | |
| Drug | Directions & Quantity | | Refills |
| Krystexxa® | <input type="checkbox"/> 8 mg Vial | <input type="checkbox"/> Infuse 8 mg intravenously (IV) every two weeks over no less than 120 minutes (Quantity: 2 doses) | |
| Uloric | <input type="checkbox"/> 40 mg Tablet <input type="checkbox"/> 80 mg Tablet | <input type="checkbox"/> Take 40 mg once daily with or without food (Quantity: 30) <input type="checkbox"/> Take 80 mg once daily with or without food (Quantity: 30) | |
| ColciGel® | <input type="checkbox"/> 15 mL <input type="checkbox"/> 30 mL (2 Pak) | <input type="checkbox"/> Apply 1-4 pumps up to four times per day (Quantity: 1) | |
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| MEDICAL INFORMATION | | | |
|--|---|--|-------------------------------------|
| ***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*** | | | |
| PREVIOUS THERAPIES: | Tried & Failed (Duration): | Not Tolerated: | Reason(s) for Discontinuing: |
| <input type="checkbox"/> _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| Date of Diagnosis: ____/____/____ | Baseline Serum Uric Acid Level: _____ mg/dL | Allergies: | |
| | Current Serum Uric Acid Level: _____ mg/dL | | |
| <input type="checkbox"/> M1A.00X0 Idiopathic chronic gout, unspecified site, <i>without</i> tophus (tophi) | | <input type="checkbox"/> M1A. _____ | |
| <input type="checkbox"/> M1A.00X1 Idiopathic chronic gout, unspecified site, <i>with</i> tophus (tophi) | | <input type="checkbox"/> Other: _____ | |
| Additional Clinical Information: | | | |

| PATIENT CONSENT TO MANUFACTURER SUPPORT PROGRAMS | |
|--|-----------------------------|
| To Patient: By signing this form and utilizing our services, you are also authorizing Senderra to gain access and enroll you in any available manufacturer supported patient programs on your behalf. | |
| Patient Signature: | Date: ____/____/____ |

| PRESCRIBING PRACTITIONER SIGNATURE | |
|---|-----------------------------|
| To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations. | |
| Prescribing Practitioner: | Date: ____/____/____ |

CONFIDENTIALITY NOTICE

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