



## ALL FIELDS ARE REQUIRED | PLEASE PRINT

This form must be completed and signed for <u>each</u> JUXTAPID prescription.

PATIENT INFORMATION				
Address:	Middle Initial: p:	Phone:		
JUXTAPID PRESCRIPTION				
0	hs (recommended starting dosage	is 5 mg daily). Quantity to dispense: _	Refills:	
PRESCRIBER INFORMATION				
	Middle Initial:	Last Name:		
Office Contact:		Office Phone:		
Address:		Office Fax:		
•		State License #:		
State: Zi	p:	NPI #:		
	PRESCRIBER ATTESTAT	ION OF REMS REQUIREMENTS		
<ul><li>apheresis where available and non-high-density lip</li><li>I affirm that my patient has</li></ul>	e, to reduce low-density lipoprotei oprotein cholesterol (non-HDL-C) i as a clinical or laboratory diagnosis	to a low-fat diet and other lipid-lower n cholesterol (LDL-C), total cholestero in patients with homozygous familial h s consistent with HoFH. I tests for this patient as directed in the	l (TC), apolipoprotein B (apo B), nypercholesterolemia (HoFH).	
Lab Testing Recommen	dations			
Prior to initiating therapy – Measure ALT, AST, alkaline phosphatase, and total bilirubin.				
During the first year	<ul> <li>Measure liver-related tests (ALT and AST, at a minimum) monthly or prior to each increase in dose whichever occurs first.</li> </ul>			
After the first year	<ul> <li>Measure liver-related tests any increase in dose.</li> </ul>	<ul> <li>Measure liver-related tests (ALT and AST, at a minimum) at least every 3 months and before any increase in dose.</li> </ul>		
	REMS Program to act on my beha by designated by the patient utilizing	alf for the limited purposes of transmiting their benefit plan.	tting this prescription to	
Prescriber Signature:	Substitution Permitted	Dispense as Written	Date	

IMPORTANT

Fax this form to 1-855-898-2498 or scan and email it to REMS@chiesi.com.

If you have any questions, please contact the JUXTAPID REMS Coordinating Center. Phone: 1-85-JUXTAPID (1-855-898-2743) | Fax: 1-855-898-2498 | www.juxtapidREMSprogram.com

