

Prescription Authorization Form



ALL FIELDS ARE REQUIRED | PLEASE PRINT

This form must be completed and signed for each JUXTAPID prescription.

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ Phone: _____
City: _____ Email: _____
State: _____ Zip: _____ Date of Birth: _____

JUXTAPID PRESCRIPTION

Dose: _____ mg po q hs (recommended starting dosage is 5 mg daily). Quantity to dispense: _____ Refills: _____
Additional Instructions: _____

PRESCRIBER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Practice/Facility Name: _____
Office Contact: _____ Office Phone: _____
Address: _____ Office Fax: _____
City: _____ State License #: _____
State: _____ Zip: _____ NPI #: _____

PRESCRIBER ATTESTATION OF REMS REQUIREMENTS

- I understand that JUXTAPID is indicated only as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH).
- I affirm that my patient has a clinical or laboratory diagnosis consistent with HoFH.
- I have obtained and will continue to obtain the liver-related tests for this patient as directed in the JUXTAPID Prescribing Information.

Lab Testing Recommendations

<i>Prior to initiating therapy</i>	– Measure ALT, AST, alkaline phosphatase, and total bilirubin.
<i>During the first year</i>	– Measure liver-related tests (ALT and AST, at a minimum) monthly or prior to each increase in dose whichever occurs first.
<i>After the first year</i>	– Measure liver-related tests (ALT and AST, at a minimum) at least every 3 months and before any increase in dose.

- I authorize the JUXTAPID REMS Program to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

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

