APPENDIX 2

PRESCRIPTOR ENROLLMENT FORM

- Online Version
- Downloadable Version
Online JUXTAPID REMS Program Prescriber Enrollment Form

You have successfully submitted your online enrollment form. You will receive a confirmation email from Centric Health Resources who administers the JUXTAPID REMS Program on behalf of Aegerion Pharmaceuticals. Click here to view/print your Online Enrollment Form.

If you have any questions, please contact the JUXTAPID REMS Program.
JUXTAPID will only be available through the JUXTAPID REMS Program. In order to prescribe JUXTAPID, a prescriber must:

1) Review the Prescribing Information (PI) and complete the Prescriber Training Module;
2) Complete this one-time JUXTAPID REMS Program Prescriber Enrollment Form; and
3) Complete and submit a JUXTAPID REMS Prescription Authorization Form for each new prescription.

Complete this enrollment form and fax it to the JUXTAPID REMS Program at 1-855-898-2498 or scan and email to REMS@aegerion.com.

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**PRESCRIBER INFORMATION**

<table>
<thead>
<tr>
<th>First Name*: ______________________________________</th>
<th>Middle Initial:</th>
<th>Last Name*: ___________________________________</th>
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| Credentials*:  
- MD  
- DO  
- NP  
- PA  
- Other:__________________________________________________________________________ |
| Physician Specialty:  
- Cardiology  
- Endocrinology  
- Internal Medicine  
- Other (specify) _____________________________ |
| Practice/Facility Name: __________________________________________________________________________________________________ |
| Address 1*: _____________________________________________________________________________________________________________ |
| Address 2: ______________________________________________________________________________________________________________ |
| City*: _____________________ State*: _____ Zip code*: ________ Phone Number*: _______________ Fax Number*: ____________________ |
| Email*: ______________________________________________________________________ NPI #: ____________________________________ |

**OFFICE CONTACT**

| First Name: _________________________________________________ | Last Name: ____________________________________________________ |
| Phone Number (if different from above): _________________________ | Fax Number (if different from above): _________________________ |
| Email* (if office contact is provided): ____________________________________________________________________________________ |

**PRESCRIBER ATTESTATION**

By completing this form, I attest that:

- I understand that JUXTAPID is indicated 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 understand that JUXTAPID is only available through the JUXTAPID REMS Program and that I must comply with the program requirements in order to prescribe JUXTAPID.
- I have completed the JUXTAPID REMS Prescriber Training Module.
- I understand that there is a risk of hepatotoxicity associated with JUXTAPID.
- I understand that serum ALT, AST, alkaline phosphatase and total bilirubin must be measured before initiating therapy with JUXTAPID.
- I understand that during the first year of treatment with JUXTAPID liver-related laboratory tests (ALT and AST at a minimum) must be measured prior to each increase in dose or monthly, whichever comes first.
- I understand that after the first year, these parameters should be measured at least every 3 months and before any increase in dose.
- I agree that personnel from the JUXTAPID REMS Program may contact me to gather further information or resolve discrepancies or to provide other information related to JUXTAPID or the JUXTAPID REMS Program.
- I will complete and submit a JUXTAPID REMS Program Prescription Authorization Form for each new prescription.
- I agree that Aegerion, its agents and contractors such as the pharmacy providers may contact me via phone, mail, or email to survey me on the effectiveness of the program requirements for the JUXTAPID REMS Program.

Signature*: ___________________________________________________________________________ Date*: ____________________________

Reference ID: 3356376