APPENDIX 5

PRESCRIPTION AUTHORIZATION FORM
Instructions: This form should be completed for each new prescription. Please print – all fields are required. This form consists of 3 parts: (1) Patient Information; (2) Prescription; and (3) Prescriber Information and Attestation of REMS Requirements.

Please FAX completed form to JUXTAPID REMS Program at 1-855-898-2498 or scan and email to REMS@aegerion.com; either will route directly to the certified pharmacy.

PATIENT INFORMATION

First Name: _____________________________________ Last Name: ____________________________ Date of Birth: _______________________
Address: _____________________________________________________________ City: _________________________ State: _____ Zip: _______

JUXTAPID PRESCRIPTION

Dose: _________ mg po q hs (recommended starting dosage is 5 mg daily). Quantity to dispense: _____________ Refills:____________

Additional Instructions:_____________________________________________________________________________________________________

PRESCRIBER INFORMATION and ATTESTATION OF REMS REQUIREMENTS

Prescriber Information:

First Name: ________________________________________________ Last Name: ___________________________________________________
Practice/Group Name: __________________________________________ Office Contact Person: _____________________________________
Address 1: ________________________________________________________________________________________________________________
Address 2: ___________________________________________________________________________________________ Suite: ______________
City: ______________________________________________________________________State: __________________ Zip: ___________________
Office Phone: ____________________________________________________ Office Fax: _____________________________________________
License #: ______________________________________________________________________ NPI #: __________________________________

Attestation of REMS Requirements:

• 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 affirm that my patient has a clinical or laboratory diagnosis consistent with HoFH.
• I understand that JUXTAPID has not been studied in pediatric patients less than 18 years.
• I attest that I have obtained the liver-related laboratory tests for this patient as directed in JUXTAPID’s prescribing information.

Prescriber Signature ______________________________________________________ Date ______________________

Substitution Permitted Dispense as Written

JUXTAPID REMS Program information may be found at www.JUXTAPIDREMSProgram.com or by calling 1-85-JUXTAPID (1-855-898-2743).

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