

**APPENDIX 5**

**PRESCRIPTION AUTHORIZATION FORM**



# JUXTAPID REMS PROGRAM 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 \_\_\_\_\_  
Substitution Permitted \_\_\_\_\_ Dispense as Written \_\_\_\_\_ Date \_\_\_\_\_

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