

**Instructions:** Complete both **pages** of this form for each new prescription. All fields are required. Please Print.  
**Please FAX completed form to MYALEPT REMS Program at 1-877-328-9682.**  
 The prescription for MYALEPT is only valid if received by fax.  
 For New York prescribers: In addition to this completed form, provide New York specific prescription blanks.

Patient Information			
Full Name (first, middle, last)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Address		City	State      ZIP code
Preferred phone number	Alternate phone number		Preferred time to contact: (check one) <input type="checkbox"/> Day <input type="checkbox"/> Evening
Email		Alternate contact/phone #	
Parent/Guardian (if applicable)			
Insurance Information – Please copy and attach the front and back of the insurance card.			
Insurance company phone number			
Insured Name		Relationship to patient	
Insured Employer			
Prescription card <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, carrier _____			
Policy Number			
Is the patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Policy number		Group Number	
Shipping Information			
Full Name (first, middle, last)			
Address (if different from above)		City	State      ZIP code
Send initial shipment to prescribing doctor's office <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescriber Information			
Full Name (first, middle, last)			
Practice / Facility Name		Office Contact Person	
Address 1			
Address 2		City	State      ZIP code
Office Phone number	Office Fax number	License #	NPI #

**Attestation of REMS Requirements. By completing this form, I attest that:**

- I understand that MYALEPT is indicated as an adjunct to diet as replacement therapy to treat the complications of leptin-deficiency in patients with congenital or acquired generalized lipodystrophy.
- I affirm that my patient has a clinical diagnosis consistent with generalized lipodystrophy, and that my patient (or their caregiver) has been properly informed of the benefits and risks of MYALEPT therapy.
- I understand that MYALEPT is not indicated for the treatment of complications of partial lipodystrophy.
- I understand that MYALEPT is not indicated for the treatment of liver disease, including non-alcoholic steatohepatitis (NASH).
- I understand that MYALEPT is not indicated for use in patients with HIV-related lipodystrophy.
- I understand that MYALEPT is not indicated for use in patients with metabolic disease including diabetes mellitus and hypertriglyceridemia without concurrent evidence of congenital or acquired generalized lipodystrophy.
- I understand that MYALEPT is contraindicated in patients with general obesity not associated with congenital leptin deficiency.
- I understand that MYALEPT is associated with serious adverse events due to the development of anti-metreleptin antibodies that neutralize endogenous leptin and/or MYALEPT.
- I agree to test for neutralizing antibodies in patients who experience severe infections or if I suspect MYALEPT is no longer working (e.g., loss of glycemic control, or increases in triglycerides).
- I understand that MYALEPT is associated with a risk of lymphoma.
- I understand I must carefully consider the risks of treatment with MYALEPT in patients with significant hematological abnormalities and/or acquired generalized lipodystrophy.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

MYALEPT Prescription			
<b>Starting Dose:</b> <input type="checkbox"/> 0.06 mg/kg <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <b>Maintenance Dose:</b> _____			
Patient Weight	Days Supply	Refills #	
Directions (e.g., by subcutaneous injection once daily)			
List or Attach a List of Concomitant Medications		Allergies	
Patient Information			
Full Name (first, middle, last)			
Prescriber Information			
Full Name (first, middle, last)			
Address			
City	State	ZIP code	Office Phone
License #		NPI #	

**Physician Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Product Selection Permitted** **Dispense as Written**



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The following is a prescription form for the required ancillary supplies for MYALEPT reconstitution and administration. This can be faxed back to 1-877-328-9682 with the rest of this page and the previous page, or torn off and given to your patient to fill at another pharmacy.

Patient Information			
Full Name (first, middle, last)			
MYALEPT Supplies Prescription			
Required supplies (please note - the maximum number per supply is specified below. Pharmacy will adjust to individual patient needs).			
<b>For Reconstitution</b> <input type="checkbox"/> 5 of 30 mL vials of BWFI Refills # _____ <input type="checkbox"/> 31 of 5 mL vials of SWFI (use for neonates and infants) Refills # _____ <input type="checkbox"/> 62 of 3mL syringe (22G x 1 in. needle) Refills # _____		<b>For Administration</b> <input type="checkbox"/> 62 of 1mL tuberculin syringe (26 G x 3/8 in. needle) Refills # _____	
Prescriber Information			
Full Name (first, middle, last)			
Address			
City	State	ZIP code	Office Phone
License #		NPI #	

**Physician Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Product Selection Permitted** **Dispense as Written**