NATPARA REMS Program: Pharmacy Enrollment Form

To become certified, the pharmacy must designate an authorized Pharmacy Representative to coordinate the setting’s activities and assure compliance with the NATPARA® Risk Evaluation and Mitigation Strategy (REMS) Program.

INSTRUCTIONS:
Fax completed form to the NATPARA REMS Program Coordinating Center at 1-844-NAT-REMS (628-7367) or scan form and e-mail it to NATPARAREMS@npsp.com. You will receive an enrollment confirmation within 2 business days after your form is received.

NATPARA is only available through the NATPARA REMS Program. Because of the risk of osteosarcoma associated with NATPARA, only certified pharmacies may dispense NATPARA.

Authorized Pharmacy Representative Responsibilities

As the authorized Pharmacy Representative designated by my pharmacy to coordinate the activities of the NATPARA REMS Program, I agree to comply with the following program requirements:

1. Review the Prescribing Information and the NATPARA REMS Program: An Introduction information sheet.
2. Review the NATPARA REMS Training Module for Pharmacy Representatives, and answer all questions in the Knowledge Assessment.
3. Ensure all relevant staff involved in dispensing NATPARA are trained on the NATPARA REMS Program requirements as described in the NATPARA REMS Training Module for Pharmacy Representatives.
4. Put processes and procedures in place to ensure the following verifications and safe use conditions are met prior to dispensing NATPARA:
   - Verify that the prescriber is certified in the NATPARA REMS Program by reviewing the prescriber’s information against a list of REMS certified prescribers sent from the NATPARA REMS Program Coordinating Center
   - Verify that a NATPARA REMS Patient-Prescriber Acknowledgment Form has been completed and submitted by verifying that the patient and prescriber are included in a list of REMS approved patients and prescribers available through the NATPARA REMS Program Coordinating Center
5. Make available to NPS Pharmaceuticals, and/or a designated third party of FDA, documentation to verify understanding of, and adherence to, the requirements of the NATPARA REMS Program.

Please print. All information is required.

Authorized Pharmacy Representative

Name (first, middle, last): _____________________________________________________________________________________________________
Pharmacy Name: __________________________________________________________________________________________________________
Pharmacy Address: _________________________________________________________________________________________________________
City: ___________________________________ State: ___________  Zip Code:___________________ Preferred Method of Contact: ☐ Mail  ☐ E-mail
E-mail Address: ___________________________ Office Phone Number: __________________________  Office Fax Number:_____________________
Signature: ____________________________________________________________________ Date: __________________________  (MM/DD/YY)

If you have any questions, contact the NATPARA REMS Program Coordinating Center.
Phone: 1–855-NATPARA   Fax: 1-844-NAT-REMS (628-7367)   www.NATPARAREMS.com

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