



Instructions for Prescribers

The form must be signed by both the prescriber and patient. If the patient is under the age of 18 years, the form must be signed by their parent or legal guardian.\* Fax the completed form to the JUXTAPID REMS Program at 1-855-898-2498. Provide a copy of the form to patient.

PATIENT ACKNOWLEDGEMENT

Patient First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I have received, read, and understand the JUXTAPID REMS Program Patient Guide with my prescriber and I understand that:

- JUXTAPID is used along with diet and other lipid-lowering treatments in people with homozygous familial hypercholesterolemia (HoFH) to reduce:
- LDL ("bad") cholesterol - A protein that carries "bad" cholesterol in the blood (apolipoprotein B)
- Total cholesterol - Non-high-density lipoprotein cholesterol (non-HDL-C)

JUXTAPID may cause serious side effects including liver problems such as increased liver enzymes or increased fat in the liver.

- Because of these side effects, JUXTAPID is only for people with homozygous familial hypercholesterolemia (HoFH).
I will need to have blood tests to check my liver before I start and during JUXTAPID therapy. If my tests show liver problems, my doctor may lower my dose of JUXTAPID or stop it.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

PRESCRIBER ACKNOWLEDGEMENT

Prescriber First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ NPI #: \_\_\_\_\_

- I have counseled the patient (parent/guardian when appropriate) on the indication and risks of JUXTAPID, including the risk of liver problems, and the need for periodic monitoring.
I have reviewed the JUXTAPID REMS Program Patient Guide with the patient (and parent/guardian when appropriate) and provided a signed copy of this form to the patient.
I discussed all concerns and answered all questions the patient had about treatment with JUXTAPID.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_