



## MYALEPT® REMS Program Prescription Authorization Form

**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		Alternate Phone		Preferred time to contact: (check one) <input type="checkbox"/> Day <input type="checkbox"/> Evening	
Email			Alternate Contact and Phone		
Parent/Guardian (if applicable)					

### Insurance Information - Please copy and attach the front and back of the insurance card.

Insurance Company Phone					
Insured Name			Relationship to Patient		
Insured Employer					
Insurance Policy #			Insurance Group # (if applicable)		
Prescription Card? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, carrier _____					
Is the patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Medicare Policy #			Medicare Group # (if applicable)		

### 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		Office Fax		License #	
				NPI #	



**Prescriber Attestations:**

- 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.
  - for the treatment of liver disease, including non-alcoholic steatohepatitis (NASH).
  - for use in patients with HIV-related lipodystrophy.
  - 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 5mg/mL Injection Prescription**

**Starting Dose:**  0.06 mg/kg  2.5 mg  5 mg ▶ Convert dose for syringe type \_\_\_\_\_  mL  units | Patient Weight \_\_\_\_\_

**Maintenance Dose:** \_\_\_\_\_ mg/kg ▶ Convert dose for syringe type \_\_\_\_\_  mL  units | Days Supply \_\_\_\_\_ Refills # \_\_\_\_\_

Directions (e.g., by subcutaneous injection once daily) \_\_\_\_\_

Attach or List Concomitant Meds \_\_\_\_\_ Allergies \_\_\_\_\_

**Patient Information**

Full Name (first, middle, last) \_\_\_\_\_

**Prescriber Information**

Full Name (first, middle, last) \_\_\_\_\_

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

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).

**For Reconstitution**

62 of 3 mL syringe (22G x 1 in. needle) Refills # \_\_\_\_\_

Water for reconstitution (select one):

5 of 30 mL vials of BWFI Refills # \_\_\_\_\_

31 of 5 mL vials of SWFI (for neonates and infants) Refills # \_\_\_\_\_

**For Administration**

Nurse Injection Training Requested

1 mL tuberculin syringe Refills # \_\_\_\_\_

31G 6mm 1 mL insulin syringe Refills # \_\_\_\_\_

31G 6mm 3/10 mL insulin syringe Refills # \_\_\_\_\_

Other syringe size and needle gauge: \_\_\_\_\_

**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

**APPENDIX 6**

**MYALEPT REMS PROGRAM REMS LETTER TO PRESCRIBERS (INFECTIONS)**