

## PATIENT-PRESCRIBER ACKNOWLEDGMENT FORM

### For the patient:

Please read each item below. Discuss them with your doctor. Do not sign this form until you are sure you understand it.

By signing on the next page, I am stating that

1. My doctor gave me the *Mycophenolate REMS Patient Brochure: What You Need to Know About Mycophenolate*.
2. I know the risks to an unborn baby if I take mycophenolate while I am pregnant. I talked with my doctor about these risks. I understand that if I get pregnant while taking mycophenolate or within 6 weeks after I stop, there is
  - A higher risk of losing the pregnancy (miscarriage) in the first 3 months
  - A higher risk that the baby may have birth defects including:
    - Defects of the ears
    - Cleft lip or cleft palate
    - Defects of the arms, legs, heart, esophagus, kidney and nervous system
3. I know I will have pregnancy tests before I start and during my mycophenolate treatment
4. My doctor talked with me about acceptable forms of birth control.
5. Unless I choose not to have sexual intercourse with a man at any time (abstinence), I will always use acceptable birth control
  - During my entire treatment with mycophenolate
  - For 6 weeks after I stop taking mycophenolate

**Information about your birth control options is provided in the *Mycophenolate REMS Patient Brochure: What You Need to Know About Mycophenolate*** If I am thinking about having a baby during my treatment, I will talk with my doctor right away.

6. I will tell my doctor right away if I get pregnant during my treatment or within 6 weeks after I stop.
7. I know that if I become pregnant I should report it to the Mycophenolate Pregnancy Registry.

### These medicines contain mycophenolate:

- CellCept® (mycophenolate mofetil)
- Myfortic® (mycophenolic acid)
- Generic mycophenolate mofetil
- Generic mycophenolic acid

**(Please fill out form on next page)**

For complete safety information, please see the *Medication Guide*, which can be found at [www.MycophenolateREMS.com](http://www.MycophenolateREMS.com)

## PATIENT-PRESCRIBER ACKNOWLEDGMENT FORM

Patient Name (please print): \_\_\_\_\_

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

Parent/Guardian Name (if patient under age 18; please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **For the prescriber (or healthcare provider acting on behalf of the prescriber):**

I have fully explained to my patient (and her parent or guardian if the patient is under age 18) the nature and purpose of treatment with mycophenolate and the risks to females of reproductive potential as described on the previous page. I have asked the patient (and her parent or guardian) if she has any questions regarding her treatment and have answered those questions to the best of my ability.

Prescriber's/Other Healthcare Provider's Name (please print): \_\_\_\_\_

Degree: (Circle one) MD DO NP PA

Prescriber's/Other Healthcare Provider's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE RETAIN THE ORIGINAL SIGNED DOCUMENT AND PROVIDE A SIGNED COPY TO THE PATIENT.**

For more information about Mycophenolate REMS and to request resource materials, please visit [www.MycophenolateREMS.com](http://www.MycophenolateREMS.com) or call 1-800-617-8191.