Pharmacy Enrollment Form

Juxtapid (lomitapide) capsules

REMS Program

THERE ARE 2 PAGES TO THIS FORM | ALL FIELDS ARE REQUIRED | PLEASE PRINT

JUXTAPID is only available through the JUXTAPID Risk Evaluation and Mitigation Strategy (REMS)

PHARMACY

Pharmacy Name:_____ License #:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone: _____ Fax: _____

AUTHORIZED PHARMACY REPRESENTATIVE

To become enrolled as a certified pharmacy under the JUXTAPID REMS, pharmacies must designate an authorized representative for the pharmacy. The authorized representative must complete the remainder of the form.

Name:_____ Title: _____

Email: _____

Phone: _____ Fax: _____

Authorized Pharmacy Representative Attestation

As the Authorized Pharmacy Representative, I must:

- Review the JUXTAPID Prescribing Information, **Fact Sheet** and **Pharmacy Training Module**
- Successfully complete the **Knowledge Assessment** and submit it to the JUXTAPID REMS
- Establish processes and procedures to verify the prescriber is certified, the patient is enrolled, and a completed **Prescription Authorization Form** is received for each prescription
- Train all pharmacy staff involved in dispensing JUXTAPID in the requirements of the JUXTAPID REMS

Before dispensing, my pharmacy must verify that:

- The prescriber is certified
- The patient is enrolled
- A completed **Prescription Authorization Form** for the patient is received for each prescription

CONTINUED ON NEXT PAGE

At all times, my pharmacy must:

- Not distribute, transfer, loan, or sell JUXTAPID
- Maintain records documenting staff's completion of the JUXTAPID REMS training
- Maintain and submit records of prescription data to the JUXTAPID REMS
- Maintain records that all REMS processes and procedures are in place and are being followed
- Comply with audits carried out by Amryt Pharmaceuticals DAC or a third party acting on behalf of Amryt Pharmaceuticals to ensure that all processes and procedures are in place and are being followed
- Have a new authorized representative enroll by completing and submitting the **Pharmacy Enrollment Form**, if the authorized representative changes

Signature: _____ Date: _____

This form must be completed for initial pharmacy enrollment, re-certification and within 30 days after any changes to the authorized representative.

IMPORTANT

REVIEW TO ENSURE ALL FIELDS ARE COMPLETED | RETURN BOTH PAGES

Fax this form to 1-855-898-2498 or scan and email it to REMS@amrytpharma.com

If you have any questions, please contact the JUXTAPID REMS Coordinating Center.
Phone: 1-85-JUXTAPID (1-855-898-2743) | Fax: 1-855-898-2498 | www.juxtapidREMSprogram.com