Prescription Authorization Form

Juxtapid® (lomitapide) capsules

REMS Program

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

This form must be completed and signed for each JUXTAPID prescription.

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Phone: _____

City: _____ Email: _____

State: _____ Zip: _____ Date of Birth: _____

JUXTAPID PRESCRIPTION

Dose: _____ *mg po q hs* (recommended starting dosage is 5 mg daily). Quantity to dispense: _____ Refills: _____

Additional Instructions: _____

PRESCRIBER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Practice/Facility Name: _____

Office Contact: _____ Office Phone: _____

Address: _____ Office Fax: _____

City: _____ State License #: _____

State: _____ Zip: _____ NPI #: _____

CONTINUED ON NEXT PAGE

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

PRESCRIBER ATTESTATION OF REMS REQUIREMENTS

- I understand that JUXTAPID is indicated only as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH).
- I affirm that my patient has a clinical or laboratory diagnosis consistent with HoFH.
- I have obtained and will continue to obtain the liver-related tests for this patient as directed in the JUXTAPID Prescribing Information.

Lab Testing Recommendations	
Prior to initiating therapy	– Measure ALT, AST, alkaline phosphatase, and total bilirubin.
During the first year	– Measure liver-related tests (ALT and AST, at a minimum) **monthly** or prior to each increase in dose whichever occurs first.
After the first year	– Measure liver-related tests (ALT and AST, at a minimum) at least **every 3 months** and before any increase in dose.

- I authorize the JUXTAPID REMS Program to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Prescriber Signature: _____ _____ _____

Substitution Permitted | Dispense as Written | Date

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@chiesi.com.

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