KYNAMRO® REMS Program

Prescription Authorization Form

Complete all sections of this form. Please note that processing of your patient's prescription could be delayed if any section is incomplete. Fax the completed form to the KYNAMRO REMS Program Coordinating Center at 1-877-778-9008.

PATIENT INFORMATION

Name (first, middle, last)	Gender ☐ M ☐ F	Date of Birth	
Address	City	State	Zip Code
Preferred Phone Number	Alternate Contact/Phone	Preferred Time to Contact ☐ Day ☐ Evening	
Shipping Information ☐ Patient's Home Address (address above) ☐ Other Address (indicate below)			
Address	City	State	Zip Code

PATIENT INSURANCE INFORMATION

Please complete below or attach a copy of both sides of the patient's insurance and/or prescription card(s)

Patient has no insurance ☐ [If your patient does not have insurance, no further information is required in this section after you have checked this box]

Primary Insurance	**Prescription Benefit Information**
Primary Insurance Name	PBM Name
Primary Insurance Phone	Cardholder's Full Name
Policy/Rx ID	Cardholder's Date of Birth
Group Number	Policy/Group #
Policyholder's Name	BIN #
Policyholder's Date of Birth	PCN #
Relationship to Patient	

Have you provided a copy of all insurance cards? Medical Card ☐ Prescription Card ☐

KYNAMRO REMS CERTIFIED PRESCRIBER INFORMATION

Name (first, middle, last)	NPI Number		
Phone Number	Fax Number	Office Contact Name	
Practice Address	City	State	Zip Code

Attestation of KYNAMRO REMS Program Requirements:

✓ I understand that KYNAMRO is indicated only as an adjunct to lipid-lowering medications and diet to reduce low-density lipoprotein cholesterol, apolipoprotein B, total cholesterol, 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 understand that KYNAMRO has not been adequately studied in pediatric patients less than 18 years of age.

✓ I attest that I have obtained the liver-related laboratory tests for this patient as directed in the KYNAMRO Prescribing Information.

- Before initiating therapy, measure alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase, and total bilirubin
- During the first year, liver-related tests (ALT, and AST, at a minimum) must be measured monthly
- After the first year, these parameters should be measured at least every 3 months

By signing below, I attest to the REMS requirements above and also authorize the KYNAMRO REMS Program Coordinating Center to forward this prescription on my behalf to a certified pharmacy to dispense KYNAMRO to the patient named above.

KYNAMRO PRESCRIPTION

Rx: KYNAMRO® (mipomersen sodium) Injection 200 mg/mL, 1 mL Prefilled Syringe

Dx: ☐ Clinical or laboratory diagnosis consistent with HoFH (there is currently no HoFH-specific ICD-10 code)

Sig: ☐ Inject 1 mL of 200 mg/mL subcutaneously once a week **OR** ☐ _____

Dispense: ☐ Box of 4 prefilled syringes **OR** ☐ Box of 1 prefilled syringe

Refills: ☐ 11 refills ☐ _____ refills ☐ NR

☐ Dispense as written ☐ Request for Home Injection Training

Prescriber Signature_____ Date_____

Print Name_____
(No Stamps)

Questions? Contact the KYNAMRO REMS Program Coordinating Center

Phone: 1-877-596-2676 | Fax: 1-877-778-9008 | www.KYNAMROREMS.com

KYNAMRO® (mipomersen sodium) injection 200mg/ml

©2017 Kastle Therapeutics. All rights reserved. KYNAMRO is a registered trademark of Kastle Therapeutics.

KAST.KYNA.16.07.026 a