Current as of 6/1/2013. This document may not be part of the latest approved REMS.

REMS Prescription Authorization Form

Please complete all sections of this form and fax it to the KYNAMRO™ REMS Program at 877-778-9008. If you have any questions, contact the KYNAMRO REMS Program at 877-596-2676.

Patient Information (Please print. All information marked with an * is required.)

Full Name (first, middle, last)*		Gender* ☐M ☐ F	Date of Birth*
Address*	City*	State*	Zip*
Preferred Phone Number*	Alternate Phone Number		Preferred Time to Contact ☐ Day ☐ Evening
Email Address	Alternate Contact/Phone		

Shipping Information Ship to ☐ Patient's Home Address (address above) ☐ Other Address (indicate below)

Name	Address	City	State	Zip	Phone Number

Insurance Information (Please print.)

Primary Insurance Name		Primary Insurance Phone
Policy Holder's Name	Policy Holder's Date of Birth	Relationship to Patient
Policy/Rx ID	Group Number	
Secondary Insurance Name		Secondary Insurance Phone
Policy Holder's Name	Policy Holder's Date of Birth	Relationship to Patient
Policy/Rx ID	Group Number	

Prescription Card ☐ Yes (complete information below) ☐ Not applicable

Carrier	ID #	Policy/Group #	Cardholder's Full Name	Cardholder's Date of Birth

Prescriber Information (Please print. All information marked with an * is required.)

Prescriber's Full Name*		NPI*	
Phone Number*		Fax Number*	
Practice Street Address*	City*	State*	Zip*

Attestation of REMS Requirements:

✓I understand that KYNAMRO is indicated as an adjunct to lipid-lowering medications and diet to reduce low density lipoprotein-cholesterol (LDL-C), apolipoprotein B (apo B), total cholesterol (TC), 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.

KYNAMRO Prescription (Please print. All information marked with an * is required.)

Dosing Instructions*		Refills NR 1 2 3 4 5 6
DATE*	**PRESCRIBER SIGNATURE***	☐Dispense as Written

The KYNAMRO Prescription Authorization Form is available at www.KynamroREMS.com

Please see Prescribing Information for KYNAMRO.
KYNAMRO is a trademark of Genzyme Corporation.