KYNAMRO® REMS Program

Patient-Prescriber Acknowledgment Form

Instructions for Health Care Providers

1. Counsel the patient on the benefits and risks of KYNAMRO (mipomersen sodium) injection.
2. Complete each section of the form with the patient as required.
3. Provide a signed copy of this form to the patient along with the **KYNAMRO REMS Program Patient Guide.**
4. Fax completed Acknowledgment Form to the **KYNAMRO REMS Coordinating Center at 1-877-778-9008.**

Please note that without this form completed, the KYNAMRO prescription for your patient will be delayed.

PATIENT ACKNOWLEDGMENT OF KYNAMRO BENEFITS AND RISKS

Benefits:

- KYNAMRO is used along with diet and other lipid-lowering treatments in people with homozygous familial hypercholesterolemia (HoFH) to reduce:
  - LDL ("bad") cholesterol
  - Total cholesterol
  - A protein that carries "bad" cholesterol in the blood (apolipoprotein B)
  - Non–high-density lipoprotein cholesterol (non–HDL-C)

Risks:

- KYNAMRO may cause liver problems, such as increased liver enzymes or increased fat in the liver
- Because of these serious side effects, KYNAMRO is only for people with HoFH
- I will need to have blood tests before and during KYNAMRO treatment to check my liver's enzymes. If my tests show some liver problems, my doctor may stop treatment with KYNAMRO

By signing this form, I acknowledge that:

- I received, read, and understand the information in the KYNAMRO REMS Program Patient Guide
- My health care provider told me about the benefits and risks of KYNAMRO therapy
- My health care provider answered all of my questions or concerns about my treatment with KYNAMRO
- The risks listed on this form are not all of the risks of KYNAMRO treatment

WRITTEN PERMISSION TO SHARE INFORMATION

- I permit my health care provider to share this form with Kastle Therapeutics and their contractors. The Program Sponsors and Contractors agree to keep my information secure. They will use it only to make sure KYNAMRO REMS Program rules are being followed
- My permission lasts until the KYNAMRO REMS Program ends. I can cancel my permission at any time by providing written notice to my health care provider

_____	_____	_____/_____/_____
Signature of patient	Signature of patient representative	Date (MM/DD/YYYY)
_____	_____	_____
Printed patient name	Printed patient representative name	Relationship of patient representative to patient (if applicable)

Health Care Provider Acknowledgment

I acknowledge that prior to the initiation of this new course of KYNAMRO therapy:

- I counseled the patient on the benefits and risks of KYNAMRO by reviewing the **Acknowledgment Form**
- I discussed all concerns and answered all questions the patient had about treatment with KYNAMRO
- The patient or patient representative signed the **Acknowledgment Form**, and I provided a copy of the signed **KYNAMRO REMS Program Patient Guide** to the patient

_____
Signature of health care provider

_____
Printed name of health care provider

_____/_____/_____ _____
Date (MM/DD/YYYY) State

Questions? Contact the KYNAMRO REMS Program Coordinating Center

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

All of the KYNAMRO REMS Program documents are available at www.KYNAMROREMS.com

Please see Full Prescribing Information on KYNAMRO.com

KYNAMRO® (mipomersen sodium) injection 200mg/ml