

MYALEPT will be available only through the MYALEPT REMS Program. To prescribe MYALEPT, a prescriber must: (1) review the Prescribing Information, review and complete the Prescriber Training Module, (2) complete this one-time MYALEPT REMS Program Prescriber Enrollment Form, and (3) complete and submit a MYALEPT REMS Prescription Authorization Form for each new prescription.

Complete this enrollment form and fax it to the MYALEPT REMS Program at 1-877-328-9682.

Prescriber Information (Please Print *indicates a required field.)

Full Name (first, middle, last)*			
Credentials* <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other (specify) _____			
Physician Specialty*			
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Cardiology	
<input type="checkbox"/> General Internal Medicine	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Other _____	
Who do you treat? <input type="checkbox"/> Adults <input type="checkbox"/> Pediatrics <input type="checkbox"/> Both			
Practice / Facility Name			
Address 1*			
Address 2 (optional)		City*	State* ZIP code*
Phone number*	Alternate phone number*	Fax number*	
Email*		NPI #*	
Practice Setting* <input type="checkbox"/> Solo private practice <input type="checkbox"/> Group private practice <input type="checkbox"/> Academic/Hospital affiliated practice			
<input type="checkbox"/> Government Institution <input type="checkbox"/> Other _____			

Office Contact

Full Name (first, middle, last)*		
Phone number (if different from above)	Fax number (if different from above)	Email (if different from above)

Prescriber Attestations:

- I understand that MYALEPT is indicated as an adjunct to diet as replacement therapy to treat the complications of leptin-deficiency in patients with congenital or acquired generalized lipodystrophy.
- I affirm that my patient has a clinical diagnosis consistent with generalized lipodystrophy, and that my patient (or their caregiver) has been properly informed of the benefits and risks of MYALEPT therapy.
- I understand that MYALEPT is not indicated for:
 - the treatment of complications of partial lipodystrophy.
 - for the treatment of liver disease, including non-alcoholic steatohepatitis (NASH).
 - for use in patients with HIV-related lipodystrophy.
 - for use in patients with metabolic disease including diabetes mellitus and hypertriglyceridemia without concurrent evidence of congenital or acquired generalized lipodystrophy.
- I understand that MYALEPT is contraindicated in patients with general obesity not associated with congenital leptin deficiency.
- I understand that MYALEPT is associated with serious adverse events due to the development of anti-metreleptin antibodies that neutralize endogenous leptin and/or MYALEPT.
- I agree to test for neutralizing antibodies in patients who experience severe infections or if I suspect MYALEPT is no longer working (e.g., loss of glycemic control, or increases in triglycerides).
- I understand that MYALEPT is associated with a risk of lymphoma.
- I understand I must carefully consider the risks of treatment with MYALEPT in patients with significant hematological abnormalities and/or acquired generalized lipodystrophy.

Signature* _____

Date* _____