FINTEPLA REMS Patient Enrollment Form

FOR PATIENTS

Instructions:

Complete this form with your healthcare provider and submit:

- Online at www.FinteplaREMS.com
- By fax to 1-833-568-6198
- By mail to 1710 N Shelby Oaks Dr, Ste 3, Memphis, TN 38134

PATIENT INFORMATION

* indicates required field.

First Name*:	Phone*: Home: - - Work: - -
Last Name*:	Cell: - -
Date of Birth (MM/DD/YYYY)*: / /	Email*:
Gender*: ☐ Male ☐ Female ☐ Neutral ☐ Prefer not to say	Best Time to Call: ☐ AM ☐ PM
Race*: ☐ Black or African American ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other (please specify)	Okay to Leave Message*: ☐ Yes ☐ No
	Legal Guardian Name:
	Relationship:
Ethnicity*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Legal Guardian Phone: - -
Address Line 1*:	Legal Guardian Email:
Address Line 2:	
City*: State*: ZIP Code*:	

PRESCRIBER INFORMATION

* indicates required field.

First Name*:	Address Line 1*:
Last Name*:	Address Line 2:
National Provider Identifier (NPI)*:	City*: State*: ZIP Code*:
REMS ID*:	Phone*: - -
Email:	Fax*: - -

PATIENT AGREEMENT

- I have received, read, and understand the *Patient Guide* that my healthcare provider has given me

Before my treatment begins:

- I will enroll in the REMS by completing this *Patient Enrollment Form* with my healthcare provider
- I will get an echocardiogram (ECHO) to check my heart

My healthcare provider has counseled me on:

- The risk of developing heart valve problems and high blood pressure in my lung arteries
- Recognizing the signs and symptoms associated with these risks
- The importance of getting a test called an echocardiogram (ECHO) before starting FINTEPLA, every 6 months during treatment, and once 3 to 6 months after I stop treatment

During treatment, every 6 months:

- I will receive counseling from my healthcare provider on the importance of getting an echocardiogram (ECHO)
- I will get an echocardiogram (ECHO) to check my heart

After stopping treatment, 3 to 6 months after my final dose:

- I will get one last echocardiogram (ECHO) to check my heart

At all times:

- I will let all my healthcare providers know that I am taking FINTEPLA

I will also tell my healthcare provider if I am having any of these signs or symptoms:

- Shortness of breath
- Rapid heartbeat
- Fatigue
- Swelling of ankles and feet
- Dizziness or fainting spells
- Chest pressure or pain

I understand that:

- UCB, Inc. and its agents may contact me via phone, mail, fax, or email to support administration of the REMS
- UCB, Inc. and its agents may use and share my personal health information, including echocardiogram (ECHO) results and prescription data collected as part of the REMS for the purpose of the operations, analysis, and reporting of the REMS, including enrolling me into, administering, and evaluating the REMS, coordinating the dispensing of FINTEPLA, and releasing my personal health information to the Food and Drug Administration (FDA), as necessary
- In order to receive FINTEPLA, I am required to be enrolled in the REMS, and my information will be stored in a database of all patients who receive FINTEPLA in the United States

_____ **Signature** / / **Date** ☐ Parent/Legal Guardian ☐ Patient (if applicable)

PRESCRIBER AGREEMENT

By signing below, I acknowledge that I have reviewed the risks of FINTEPLA and the requirements of the REMS with this patient.

_____ **Prescriber Signature** / / **Date**

Fintepla® (fenfluramine) 2.2 mg/mL oral solution