FILSPARI® REMS PRESCRIBER ENROLLMENT FORM

Instructions:

1. Review the Prescribing Information, and the **Prescriber and Pharmacy Guide**.
2. Enroll by completing and submitting this **Prescriber Enrollment Form** to the REMS by fax to 1-833-483-4736.
   - Prescriber enrollment can also be completed online at www.FILSPARIREMS.com

Complete all required fields on this form to avoid a delay in the enrollment process.

1 Prescriber Information *(*indicates required field)*

*First Name:	Middle Initial:	*Last Name:	*National Provider Identifier (NPI) #:

*Specialty (select one):
☐ Nephrology ☐ Other (please specify):_____

*Professional Designation (select one):
☐ MD ☐ DO ☐ PA ☐ NP

Office Practice/Clinic Name:

*Address Line #1:	Address Line #2:	
*City:	*State:	*Zip:

Preferred Method of Contact (select one): ☐ Fax ☐ Email *Email:

*Office Phone:	*Fax:	Mobile Phone:

Primary Office Contact Information

First Name:	Last Name:	
Address Line #1:	Address Line #2:	
City:	State:	Zip:

Phone:	Fax:	*Email (required if Office Contact is provided):

Secondary Office Contact Information

First Name:	Last Name:	
Address Line #1:	Address Line #2:	
City:	State:	Zip:

Phone:	Fax:	*Email (required if Office Contact is provided):

2 Prescriber Agreement

By completing, signing, and submitting this form, I agree and acknowledge that:

To become certified to prescribe, I must:

- Review the drug's Prescribing Information.
- Review the **Prescriber and Pharmacy Guide**.
- Enroll in the REMS by completing the **Prescriber Enrollment Form** and submitting it to the REMS.

Before treatment initiation (first dose), I must:

- Counsel the patient on the:
  - Risk of hepatotoxicity associated with FILSPARI
  - Signs and symptoms of liver problems
  - Need to contact the prescriber if the patient has any signs or symptoms of liver problems
  - REMS requirements including the need to complete liver testing every 3 months during treatment
  - FILSPARI is only available through a restricted distribution program using the **Patient Guide**.
- Assess the patient's liver function. Document and submit to the REMS using the **Patient Enrollment Form**.
- Provide the patient with the **Patient Guide**.
- Enroll the patient by completing the **Patient Enrollment Form** and submitting it to the REMS.

During treatment, every 3 months, I must:

- Assess the patient's liver function.
- Counsel the patient on the risk of hepatotoxicity if they are not complying with the required liver testing.

At all times, I must:

- Report adverse events suggestive of hepatotoxicity to the REMS.

Provide Signature Below

By signing below, I acknowledge the above agreements and my obligations as a FILSPARI healthcare provider to comply with FILSPARI REMS requirements, and I understand my personally identifiable information provided above will be shared with Travere Therapeutics, Inc., its agents or contractors and entered into a database for the FILSPARI REMS. I agree that I may be contacted in the future by mail, email, fax, and/or phone concerning FILSPARI, the FILSPARI REMS, and other FILSPARI programs and services.

***Healthcare Provider Signature:**	***Date (MM/DD/YYYY):**

Report adverse events suggestive of hepatotoxicity to the FILSPARI REMS at 1-833-513-1325. Report all other suspected adverse events or product quality complaints associated with FILSPARI to Travere Therapeutics, Inc. at 1-877-659-5518 or the FDA at 1-800-FDA-1088 or online at www.fda.gov/medwatch.