PALFORZIA REMS Patient Enrollment Form

PALFORZIA® is available only through the PALFORZIA REMS (Risk Evaluation and Mitigation Strategy); a restricted program. Only prescribers, healthcare settings, pharmacies, and patients enrolled in the program can prescribe, administer, dispense, and receive PALFORZIA. Your healthcare provider will help you complete this form and provide you with a copy.

PRESCRIBER INSTRUCTIONS:

1. Review the *Patient Enrollment Form* with the patient or parent/guardian and answer any questions the patient or parent/guardian has about PALFORZIA.
2. Complete and submit the *Patient Enrollment Form* online at www.PALFORZIAREMS.com or by fax to 1-844-285-2013.

Complete all mandatory fields on this form to avoid a delay in the enrollment process. Upon completion of the form, the REMS Program will notify the prescriber of successful patient enrollment within 2 business days.

PRESCRIBER INFORMATION

(*indicates required field)

First Name*: PHILIP	Last Name*: HEMMERS	National Provider Identifier (NPI #)*: 1386700854
Practice/Facility Name*: ALLERGY CENTER OF CONNECTICUT		
Address 1*: 4 CORPORATE DRIVE, SUITE 295		
Address 2:		
City*: SHELTON	State*: CT	ZIP*: 06484
Office Phone Number *: (203) 374-6103	Email Address*: N/A	

Signature * _____ Date* _____

PATIENT INFORMATION

(*indicates required field)

First Name*:	MI:	Last Name*:	Date of Birth*: (MM/DD/YYYY)	Sex*: ☐ Female ☐ Male ☐ Other
Address 1*:		Address 2:		
City*:		State*:	ZIP*:	
Phone Number:		Email Address:		
Parent/Guardian First Name*:		Parent/Guardian Last Name*:		
Relationship to Patient*:		Parent/Guardian Phone Number*: ☐ Same as above		
Email Address of Parent/Guardian *: ☐ Same as above				

PATIENT AGREEMENT

By signing this form, the patient/parent/guardian acknowledges the following:

Before treatment begins:
- Enroll in the PALFORZIA REMS by completing this *Patient Enrollment Form* with prescriber
- Receive counseling on the need to have injectable epinephrine available for immediate use at all times, the need for monitoring with the Initial Dose Escalation and the first dose of each Up-Dosing level, the need for continued peanut avoidance in the diet, and how to recognize the signs and symptoms of severe allergic reaction (anaphylaxis)

During treatment *(before the first dose of each Up-Dosing level)*:
- Receive counseling from a healthcare provider on the need to be monitored for severe allergic reaction (anaphylaxis)

During treatment (*during and after administration of the Initial Dose Escalation and the first dose of each Up-Dosing level, for at least 60 minutes*):
- Be monitored for severe allergic reaction (anaphylaxis) at the healthcare setting

Patient/parent/guardian will:
- Report anaphylaxis to your healthcare provider
- Request more injectable epinephrine as needed
- Have injectable epinephrine available for immediate use at all times
- Avoid peanuts and foods that contain peanuts in the diet

Patient/parent/guardian understands:
- In order to receive PALFORZIA, patient is required to be enrolled in the REMS, and patient's information will be stored in a database of all patients who receive PALFORZIA in the United States
- Aimmune Therapeutics, Inc., and its agents, including trusted vendors, may contact patient via phone, mail, fax, or email to support administration of the REMS

☐ Patient or ☐ Parent/Guardian Signature* (please select one and sign):

Patient or Parent/Guardian Signature* _____ Date* _____

Printed Parent/Guardian Name (if applicable):