TEGSEDI™ REMS
Patient Status Form

This form must be regularly completed for all patients treated with TEGSEDI as follows:

- Every 90 days following the first dispense of TEGSEDI treatment
- In the event of TEGSEDI treatment discontinuation
- At 8 weeks following notification of a discontinuation of TEGSEDI treatment

Submit the completed form:

- Online at www.TEGSEDIrems.com
- Or Fax: 1-855-4TEGREMS (855-483-4736)

Following a treatment initiation, certified prescribers must assess each patient's platelet count and renal function [estimated glomerular filtration rate (eGFR), urinalysis, and urine protein to creatinine ratio (UPCR)] and appropriateness of continuing treatment as follows:

- Platelet count: Every week or more frequently as described in the Prescribing Information
- Renal function: Every 2 weeks

After a treatment discontinuation, the patient's platelet count and renal function must continue to be monitored for 8 weeks as follows:

- **Platelet count: Every week**
- **Renal function: Every two weeks**

NOTE: The completion of laboratory tests and the submission of this form are done at different intervals.

PRESCRIBER INFORMATION (*required)		
National Provider Identifier #*:		
First Name*:	Last Name*:	
Practice/Facility Name:		
Address Line 1:		
Address Line 2:		
City:	State:	Zip Code:
Phone:	Fax:	Email:

PATIENT INFORMATION (PLEASE PRINT) (*required)		
First Name*:	Last Name*:	Birthdate* (MM/DD/YYYY):
Address Line 1*:		
Address Line 2:		
City*:	State*:	Zip Code*:

Tegsedi™ (inotersen) injection 284 mg/1.5 mL

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1.	I have assessed the patient's signs and symptoms and reviewed the patient's required laboratory tests [platelet count, estimated glomerular filtration rate (eGFR), urinalysis, and urine protein to creatinine ratio (UPCR)] during this reporting period.	☐ Yes ☐ No
2.	Patient status:	
	2a. The patient is continuing therapy with TEGSEDI:	☐ Yes ☐ No
	2b. If YES, the patient is continuing therapy with TEGSEDI, I have assessed the patient's signs and symptoms and required laboratory tests during this reporting period and confirm this patient is appropriate to continue to receive TEGSEDI:	☐ Yes ☐ No
	2c. If NO, the patient has discontinued therapy with TEGSEDI, please indicate the reason(s): ☐ Thrombocytopenia ☐ Death ☐ Glomerulonephritis ☐ Other _____ ***Please report all Adverse Events to Akcea Therapeutics at 1-833-642-5232***	
3.	Did the patient experience serious bleeding with severe thrombocytopenia (platelet count $<50 \times 10^9$/L)?	☐ Yes ☐ No
4.	If the answer to question 3 is YES, did the patient have a platelet measurement within 2 weeks of the start of bleeding?	☐ Yes ☐ No
5.	Was the patient diagnosed with glomerulonephritis?	☐ Yes ☐ No
6.	Is the above-named patient still under the care of the prescriber identified above?	☐ Yes ☐ No
7.	If the answer to question 6 is NO, please indicate the name of the prescriber now responsible for this patient's care: Prescriber Name: _____ Prescriber Phone Number: _____ ☐ Prescriber now responsible for this patient's care is unknown.	

Print Name*:	
Certified Prescriber Signature*: X _____	Date* (MM/DD/YYYY):

Please note: The certified prescriber of record is responsible for compliance with the TEGSEDI REMS requirements, including monitoring, evaluation, and management of each patient under his/her care. If you have questions on this information, please call 1-844-483-4736.

Phone: 1-844-483-4736 | www.TEGSEDIrems.com | Fax: 1-855-483-4736

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