

## PATIENT-PRESCRIBER ACKNOWLEDGMENT FORM

### These medicines contain mycophenolate:

- CellCept® (mycophenolate mofetil)
- Myfortic® (mycophenolic acid)
- Generic formulations of mycophenolate mofetil
- Generic formulations of mycophenolic acid

### For the patient:

Please read each item below. Discuss them with your doctor. Do not sign this form until you are sure you understand it.

By signing on the next page, I am stating that

1. My doctor gave me the *Mycophenolate REMS Overview & Your Birth Control Options* booklet.
2. I know the risks to an unborn baby if I take mycophenolate while I am pregnant. I talked with my doctor about these risks. I understand that if I get pregnant while taking mycophenolate or within 6 weeks after I stop, there is
  - A higher risk of losing the pregnancy (miscarriage) in the first 3 months
  - A higher risk that the baby will have birth defects
3. I know I will have pregnancy tests before I start and during my mycophenolate treatment.
4. My doctor talked with me about acceptable forms of birth control.
5. Unless I choose not to have sexual intercourse with a man at any time (abstinence), I will always use acceptable birth control
  - During my entire treatment with mycophenolate
  - For 6 weeks after I stop taking mycophenolate

**Information about your birth control options is provided in the *Mycophenolate REMS Overview & Your Birth Control Options* booklet.**

6. If I am thinking about having a baby during my treatment, I will talk with my doctor right away.
7. I will tell my doctor right away if I get pregnant during my treatment or within 6 weeks after I stop.
8. I know that my doctor will report any pregnancies to the Mycophenolate Pregnancy Registry.

**(Please fill out form on next page)**

## PATIENT-PRESCRIBER ACKNOWLEDGMENT FORM

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (if patient under age 18; please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For the prescriber (or healthcare provider acting on behalf of the prescriber):**

I have fully explained to my patient (and her parent or guardian if the patient is under age 18) the nature and purpose of treatment with mycophenolate and the risks to females of reproductive potential as described on the previous page. I have asked the patient (and her parent or guardian) if she has any questions regarding her treatment and have answered those questions to the best of my ability.

Prescriber's/Other Healthcare  
Provider's Name (please print): \_\_\_\_\_

Degree: (circle one)    MD    DO    NP    PA

Prescriber's/Other Healthcare  
Provider's Name (signature): \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE RETAIN THE ORIGINAL SIGNED DOCUMENT  
AND PROVIDE A COPY TO THE PATIENT.**

For more information about Mycophenolate REMS and to request source materials,  
please visit [www.MycophenolateREMS.com](http://www.MycophenolateREMS.com) or call **1-800-617-8191**.