

Tesofensine Consent Form

Tesofensine (TE) is an oral serotonin-noradrenaline-dopamine reuptake inhibitor in phase III of clinical trials. TE is used as an appetite suppressant/thermogenic to help reduce caloric intake and increase energy consumption.

While using Tesofensine, it is highly recommended that you:

- Reduce calorie intake and increase physical activity
- Report any side effects to prescriber

Do not take this medication if:

- You are 75 years of age or older
- You have had previous myocardial infarction or stroke, cardiac arrhythmia, history of hypertension
- You have reduced renal function
- You are being treated for depression
- You are pregnant, lactating, or planning to become pregnant
- You have a known hypersensitivity or side effects to Tesofensine

Possible side effects*

- Nausea, dry mouth, flatulence, diarrhea, constipation, abdominal pain, insomnia, dizziness, and/or headache/migraine

Possible drug interactions

- Caution advised with the use of other Monoamine Uptake Inhibitors, (es/citalopram, fluoxetine, fluvoxamine, clomipramine, imipramine, bupropion)
- Caution advised with the use of CYP450-3A4 inhibitors (clarithromycin, erythromycin, diltiazem, itraconazole, ketoconazole, ritonavir, verapamil, grapefruit, etc.)
- Caution advised with the use of cholinergic medications such as, but not limited to, atropine, benztropine, scopolamine, diphenhydramine (Benadryl), oxybutynin.

*A serious allergic reaction to this drug is rare. However, seek medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, or trouble breathing. In the event of any emergency, call 911 immediately. Report adverse side effects to your doctor or pharmacist.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OF THIS TREATMENT, OR ANY QUESTIONS CONCERNING THIS TREATMENT, ASK THE STAFF NOW.

By signing, I certify that I have read and understand the contents of this form. I am aware of the possible side effects and drug interactions and give my consent for treatment. I have informed the medical staff of any known allergies to drugs or other substances, and any past adverse reactions I've experienced. I have informed the medical staff of all medications and supplements I'm currently taking. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and acknowledge that no guarantees have been made to me concerning my results.

Print Patient Name

Date of Birth

Patient Signature

Date Signed