

MEDICAL ALERT!

I am taking **YORVIPATH[®]** (palopegteriparatide).

! My dose of YORVIPATH is _____ mcg/day.

Additional medication(s)	Dose
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.....
.....
.....
.....

ALLERGIES:

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Yorvipath[®] 
palopegteriparatide
Injection 300 mcg/mL

Name: **Date of birth:**

Primary health care provider: **Phone #:**

Medical condition(s):

Additional medication(s):

Emergency contact: **Phone #:**



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Pharma Group. US-COMMPH-2600217 05/26