

**HOSPITAL PHARMACY'S ACCEPTANCE OF
RESPONSIBILITIES**

Plenaxis[®] PLUS Program

For safety reasons, the marketing of Plenaxis[®] is restricted. The Plenaxis[®] **PLUS** Program (Plenaxis[®] User Safety Program) ensures hospital pharmacies understand that only physicians who are enrolled with PRAECIS PHARMACEUTICALS INCORPORATED and are listed in the Plenaxis[®] Prescriber's Registry should prescribe Plenaxis[®]. Hospital pharmacies must accept the responsibilities below to receive Plenaxis[®] from PRAECIS PHARMACEUTICALS INCORPORATED or its distributors.

- I understand that because of the risk of immediate-onset systemic allergic reactions, including hypotension and syncope, and because of the risk of loss of effectiveness over time, Plenaxis[®] is only indicated for the palliative treatment of men with advanced symptomatic prostate cancer, in whom LHRH agonist therapy is not appropriate and who refuse surgical castration, and have one or more of the following: (1) risk of neurological compromise due to metastases, (2) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or (3) severe bone pain from skeletal metastases persisting on narcotic analgesia.

- Before dispensing a unit (one 100 mg dose) of Plenaxis[®], hospital pharmacists will:

Verify that the prescriber is enrolled in the Plenaxis[®] Prescribers' Registry AND obtain a confirmation number for ***each*** unit (one 100 mg dose) of Plenaxis[®] dispensed.

Physician Registry participation can be verified and confirmation numbers obtained via the interactive voice response (IVR) telephone number, 1-866-PLENAXIS (1-866-753-6294).

NOTE: When you submit this completed Acceptance of Responsibilities, your pharmacy will receive a unique "PIN" number. You must use this PIN number when you verify physician enrollment in the Registry or obtain a confirmation number for each unit of Plenaxis[®] your pharmacy dispenses.

Dispense all doses of Plenaxis[®] with Patient Information

I understand that I may withdraw my enrollment in the Plenaxis[®] **PLUS** Program by a written statement submitted to PRAECIS PHARMACEUTICALS INCORPORATED (contact information below) or that PRAECIS PHARMACEUTICALS INCORPORATED may withdraw this pharmacy from the Plenaxis[®] **PLUS** Program if they do not meet the agreed upon responsibilities.

By signing below, on behalf of this pharmacy, I acknowledge and accept the above responsibilities.

Print Name _____

Signature _____

Title _____

Date _____

Hospital Pharmacy License # _____

Hospital Pharmacy Name _____

Shipping Address _____

City _____ State/Zip _____

Billing Address _____

City _____ State/Zip _____

Phone _____ Fax _____

E-mail _____

You may also complete this form online by visting www.plenaxisplus.com

Fax completed and signed form to: **PRAECIS PHARMACEUTICALS INCORPORATED**

Attention: Plenaxis[®] **PLUS** Program

c/o SENTRX

Overlook at Great Notch

150 Clove Road

Little Falls, New Jersey 07424

Fax Number: 1-800-648-8180

Request additional materials

Package Inserts

Patient Information

Physician Attestations

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