

SABRIL REMS PROGRAM PATIENT/PARENT/LEGAL GUARDIAN–PHYSICIAN AGREEMENT FORM

SABRIL® (vigabatrin) is available only through a restricted distribution REMS program called the SABRIL REMS Program. The SABRIL REMS Program is available to answer questions regarding this program and initiating treatment with SABRIL. Please call 1-888-457-4273 when necessary.

To the Physician:

Completed forms must be submitted via fax to the SABRIL REMS Program (1-877-742-1002) prior to treatment initiation. Place the original signed document in the patient's medical record and provide a copy to the patient, parent, or legal guardian.

For the Patient or Parent/Legal Guardian:

Patient—I, _____, am the patient. I am able to read and understand this document and will sign for myself.

OR

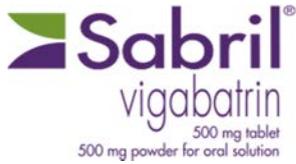
Parent/Legal Guardian—I am the parent/legal guardian of _____, who is the patient. I am able to read and understand this document and will sign it where appropriate on behalf of the patient.

To use SABRIL appropriately, the patient/parent/legal guardian should:

- Be aware that SABRIL can cause serious vision problems in some people
- Be provided and have read *What You Need to Know About SABRIL Treatment: A Patient Guide*
- Be counseled by the prescriber regarding the risks associated with SABRIL, including permanent vision loss
- Be counseled by the prescriber regarding the need for periodic monitoring of vision, including ophthalmologic assessments, based on the recommendations in the Prescribing Information
- Report any problems you/your child might experience when using SABRIL to the doctor as soon as they happen
- Visit the doctor regularly to make sure that SABRIL continues to be right for you/your child to take

This agreement is to be completed and signed by the patient/parent/legal guardian and the doctor. Each person who signs must read each item below and, if every item is understood, sign where indicated at the end of this agreement. Do not sign this agreement, or take SABRIL yourself, or give SABRIL to your child, if there are any unanswered questions.

I, _____, have been provided and have read *the What You Need to Know About SABRIL Treatment: A Patient Guide*. The doctor has explained the risk of permanent vision loss, and the need for periodic vision testing and the recommended times that the tests should be done.



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1. The doctor and I have talked about my/my child's epilepsy. We have also talked about the potential benefits and risks of taking SABRIL.
2. I understand that SABRIL will be prescribed for me or my child only. I will not share SABRIL with other people.
3. The doctor has discussed with me other treatments for my/my child's epilepsy. We have decided that SABRIL is the right treatment. I understand that SABRIL can be discontinued at any time. I also know that I/my child cannot stop taking SABRIL without the doctor telling me to do so. I agree to tell the doctor if a decision is made to stop taking SABRIL. I understand that if my/my child's treatment is abruptly stopped, my/my child's seizures might increase or return.
4. All my questions were answered to my satisfaction. I now authorize the doctor, _____, to begin my/my child's treatment with SABRIL.

I have read and understood all of the information presented above and agree to use SABRIL therapy and agree to participate in the SABRIL REMS Program.

Patient/Parent/Legal Guardian Agreement

To be signed by patient/parent/legal guardian upon initiation of SABRIL therapy.

Signature: _____ Date: _____
month/day/year

Patient Name: _____ Telephone: _____
Area Code Telephone Number

Patient Address: _____
Street City State ZIP Code

Patient Date of Birth: _____
month/day/year

Physician Agreement

I, _____, have fully explained to the patient/parent/legal guardian the potential benefits and risks of SABRIL[®] (vigabatrin) treatment, including permanent vision loss and the need for periodic vision monitoring. I have provided the patient/parent/legal guardian with *the What You Need to Know About SABRIL Treatment: A Patient Guide* and have answered all questions regarding therapy with SABRIL. Upon completion of this agreement form, I will store a copy of the form in the patient's record and will provide the patient/parent/legal guardian a copy of the form.

To be signed by physician upon initiation of SABRIL therapy.

Signature: _____ Date: _____
month/day/year

Submit this form to the SABRIL REMS Program (fax:1-877-742-1002)

