



SABRIL REMS PROGRAM PRESCRIBER ENROLLMENT AND 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.

SABRIL is indicated as monotherapy for pediatric patients 1 month to 2 years of age with infantile spasms (IS) and as adjunctive therapy for patients 10 years of age and older with refractory complex partial seizures (CPS) who have inadequately responded to several alternative treatments, for whom the potential benefits outweigh the potential risk of vision loss. SABRIL is not indicated as a first line agent for CPS.

By signing and completing the form below and on page 2, I acknowledge that I have reviewed the Prescribing Information for SABRIL, and I agree to be enrolled in the SABRIL REMS Program by completing and submitting this form to the SABRIL REMS Program.

As a condition of certification:

- I will enroll each patient in the SABRIL REMS Program by:
 - Counseling the patients/parents/legal guardians considering treatment on the benefits and risks of SABRIL, including permanent vision loss and the need for periodic monitoring of vision, and providing them with a copy of *What You Need to Know About SABRIL Treatment: A Patient Guide*
 - Completing the *SABRIL REMS Program Patient/Parent/Legal Guardian–Physician Agreement Form* for each patient and providing a completed copy to the patient/caregiver. I will submit the completed form to the SABRIL REMS Program and store a copy in the patient’s records
- Ensuring that periodic monitoring of vision, as described in the Prescribing Information, is performed on an ongoing basis for each patient
- Reporting any adverse event suggestive of vision loss to the SABRIL REMS Program with all available information

Prior to dispensing SABRIL, I understand that the SABRIL REMS Program will provide a confirmation of certification to the e-mail address listed on page 2

Prescriber Name _____	_____	_____	_____
	Last	First	MI
Prescriber Degree <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other	Signature _____	Date _____	_____
			month/day/year

For additional information, visit www.SabrilREMS.com or call the SABRIL REMS Program at 1-888-457-4273.

Prescriber Enrollment and Agreement Form continues on page 2
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