

XIAFLEXTM

collagenase clostridium histolyticum

REMS Program for Peyronie's Disease

NEW Enrollment

Enrollment Update

Program Use Only:
Healthcare Setting Enrollment ID#

Pharmacy/Healthcare Setting Enrollment Form for Peyronie's Disease

To enroll, the pharmacy or healthcare setting must designate an Authorized Representative to coordinate the setting's activities and assure compliance with the XIAFLEX REMS Program for Peyronie's disease.

INSTRUCTIONS: Fax completed form to **XIAFLEX at 1-877-313-1236** or mail to XIAFLEX REMS program, PO Box 13185, La Jolla, CA 92039. You will receive an enrollment confirmation within 2 business days after your form is received by Auxilium. For questions regarding the XIAFLEX REMS program for Peyronie's disease call 1-877-313-1235.

AUTHORIZED REPRESENTATIVE RESPONSIBILITIES

I understand that XIAFLEX is only available through the XIAFLEX REMS program for Peyronie's disease.

I am the Authorized Representative designated by my pharmacy or healthcare setting to coordinate the activities of the XIAFLEX REMS. I agree to comply with the following program requirements:

- Ensure that the staff responsible for dispensing and administering XIAFLEX at this healthcare setting is aware of my responsibilities as the Authorized Representative.
- Prior to dispensing XIAFLEX, confirm that the Healthcare Provider treating Peyronie's disease is specially certified in the XIAFLEX REMS program for Peyronie's disease.
- Maintain a current list of Healthcare Providers affiliated with my healthcare setting who are specially certified. The current affiliated Healthcare Providers of this healthcare setting include the individuals listed below. I will maintain this list by adding or removing affiliated Healthcare Providers as appropriate.
- Agree not to loan, sell or transfer XIAFLEX to another pharmacy, healthcare setting, prescriber, institution or distributor.
- Make available to Auxilium, and/or a designated third party or the FDA, documentation to verify understanding of, and adherence to, the requirements of the XIAFLEX REMS.

I understand that this enrollment only applies to me as the designated Authorized Representative of this pharmacy or healthcare setting. I will complete a separate enrollment form for each pharmacy or healthcare setting (unique ship-to site address) for which my designation and responsibilities extend. Failure to enroll a pharmacy or healthcare setting in the XIAFLEX REMS program for Peyronie's disease will result in the inability to receive shipments of XIAFLEX.

HCP First and Last Name Healthcare Provider Enrollment ID#

For additional Affiliated Healthcare Setting Providers please continue on page 2.

Authorized Representative (Please Print)

Signature

Date

AUTHORIZED REPRESENTATIVE

Salutation: Dr Mr Ms Mrs

First Name

MI

Last

Suffix

Fax

Phone

Phone Type

Main Direct Mobile

Email

Preferred method of contact is:

Email Phone Fax Mail

Role: Office Staff Clinician/Healthcare Provider Office Administration Other (Specify)

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AFFILIATED HEALTHCARE SETTING HEALTHCARE PROVIDERS

HCP First and Last Name	Healthcare Provider Enrollment ID#
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