

To become a FINTEPLA REMS certified pharmacy, enroll by following these steps:

STEP 1: REVIEW	STEP 2: COMPLETE AND SIGN	STEP 3: SUBMIT
<ul style="list-style-type: none"> <li>Designate an Authorized Representative</li> <li>The Authorized Representative must review the following:                             <ul style="list-style-type: none"> <li>Pharmacy Guide</li> <li>REMS Program Overview</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>The Authorized Representative must complete and sign this <i>Inpatient Pharmacy Enrollment Form</i></li> <li>If the Authorized Representative changes, the new Authorized Representative must complete and sign a new <i>Inpatient Pharmacy Enrollment Form</i></li> </ul>	<ul style="list-style-type: none"> <li>Submit this <i>Inpatient Pharmacy Enrollment Form</i> either:                             <ul style="list-style-type: none"> <li>Online at <a href="http://www.FinteplaREMS.com">www.FinteplaREMS.com</a></li> <li>Via fax to 1-833-568-6198</li> <li>Via mail to 1710 N Shelby Oaks Dr, Ste 3, Memphis, TN 38134</li> </ul> </li> </ul>

INPATIENT PHARMACY INFORMATION			
Pharmacy Name*:		Pharmacy Address Line 1*:	
Pharmacy DEA Number*:		Pharmacy Address Line 2*:	
Pharmacy National Provider Identifier (NPI)*:		City*:	State*:
Email:		ZIP Code*:	
	Phone*:	- -	Fax*:
			- -

\* indicates required field.

AUTHORIZED REPRESENTATIVE INFORMATION			
First Name*:		Phone*:	Fax:
		- -	- -
Last Name*:		Email*:	
Credentials*: <input type="checkbox"/> RPh <input type="checkbox"/> PharmD <input type="checkbox"/> BCPS <input type="checkbox"/> Other (please specify) _____		Preferred Method of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email	

AUTHORIZED PHARMACY REPRESENTATIVE AGREEMENT
<p>I am the Authorized Representative designated by my Inpatient Pharmacy to coordinate the activities of the REMS. By completing, signing, and submitting this form, on behalf of myself and my Inpatient Pharmacy, I attest that:</p> <ul style="list-style-type: none"> <li>I have reviewed the <i>Pharmacy Guide</i> and the <i>REMS Program Overview</i></li> <li>I am enrolling in the REMS</li> <li>I agree to train all relevant staff involved in dispensing FINTEPLA on the REMS requirements using the <i>Pharmacy Guide</i></li> <li>For patients initiating treatment: Before dispensing, all pharmacy staff must obtain authorization to dispense each prescription by contacting the FINTEPLA REMS to verify that the prescriber is certified, and the patient is enrolled and authorized to receive FINTEPLA</li> <li>For patients continuing treatment: Before dispensing, all pharmacy staff must obtain authorization to dispense each prescription by contacting the REMS to verify that the patient is under the care of a certified prescriber, and the patient is enrolled and authorized to receive FINTEPLA</li> <li>I will not dispense more than 15 days' supply at discharge</li> <li>I agree to ensure that all pharmacy staff do not distribute, transfer, loan, or sell FINTEPLA</li> <li>I will maintain records of dispensing information</li> <li>I will maintain records documenting staff's completion of REMS training</li> <li>I will maintain records that all REMS processes and procedures are in place and being followed</li> <li>I will ensure that all pharmacy staff comply with audits carried out by Zogenix, Inc. or a third party acting on behalf of Zogenix, Inc. to ensure that all processes and procedures are in place and are being followed</li> <li>If the authorized representative changes, this pharmacy will have the new authorized representative enroll in the REMS my completing the <i>Inpatient Pharmacy Enrollment Form</i></li> </ul>

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Signature Date