

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>Outpatient Pharmacy Enrollment Form</i></li> <li>If the Authorized Representative changes, the new Authorized Representative must complete and sign a new <i>Outpatient Pharmacy Enrollment Form</i></li> </ul>	<ul style="list-style-type: none"> <li>Submit this <i>Outpatient 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>

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

AUTHORIZED REPRESENTATIVE INFORMATION		* indicates required field.	
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 Outpatient Pharmacy to coordinate the activities of the REMS. By completing, signing, and submitting this form, on behalf of myself and my Outpatient Pharmacy, <b>I attest that:</b></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>I will ensure that, before dispensing, all pharmacy staff 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>I agree to ensure that all pharmacy staff do not distribute, transfer, loan, or sell FINTEPLA, except to certified pharmacies</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 by completing the <i>Outpatient Pharmacy Enrollment Form</i></li> </ul>

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Date