RISK EVALUATION AND MITIGATION STRATEGY (REMS)

I. GOALS

The goal of the SILIQ REMS Program is to mitigate the observed risk of suicidal ideation and behavior, including completed suicides, which occurred in subjects treated with SILIQ by:

- Ensuring that prescribers are educated about the risk of suicidal ideation and behavior observed with SILIQ therapy and the need to counsel patients about this risk.
- Ensuring that patients are informed about the risk of suicidal ideation and behavior observed with SILIQ therapy and the need to seek medical attention for manifestations of suicidal thoughts and behavior, new onset or worsening depression, anxiety, or other mood changes.

II. ELEMENTS

A. Elements to Assure Safe Use

1. Healthcare providers who prescribe SILIQ must be certified.
   a. To become certified to prescribe SILIQ, prescribers must:
      i. Review the Prescribing Information (PI) for SILIQ.
      ii. Enroll in the SILIQ REMS Program by completing the SILIQ REMS Program Prescriber Enrollment Form
   b. As a condition of certification, prescribers must:
      i. Enroll each patient in the SILIQ REMS Program by performing the following:
         1) Prior to providing the first prescription, counsel the patient that suicidal ideation and behavior (SIB), including completed suicides, have occurred in patients treated with SILIQ by informing the patient of the following key safety information:
            a) Suicidal ideation and behavior (SIB) events and symptoms may occur at any time during treatment with SILIQ.
            b) To be aware of symptoms of suicidal ideation and behavior (SIB) events and steps to take if SIB symptoms occur.
2) Complete the SILIQ REMS Program Patient-Prescriber Agreement Form for each patient. Submit the completed form to the SILIQ REMS Program and store a copy in the patient’s records.

3) Provide the patient with the SILIQ REMS Program Patient Wallet Card.
   a) Understand that patients with new or worsening symptoms of depression or suicidality should be referred to a mental health professional, as appropriate.
   b) Inform SILIQ REMS Program if an enrolled patient has discontinued therapy or is no longer under your care.

c. Bausch Health US, LLC. (Bausch Health) must:
   i. Ensure that prescribers who prescribe SILIQ are certified, in accordance with the requirements described above.
   ii. Provide all the following mechanisms for prescribers to complete the certification process for the SILIQ REMS Program: online, by email, and by fax.
   iii. Ensure that prescribers are notified when they have been certified by the SILIQ REMS Program.
   iv. Maintain a validated, secure database of prescribers who are certified to prescribe SILIQ in the SILIQ REMS Program.
   v. Ensure that prescribers meet the REMS requirements and de-certify prescribers who do not maintain compliance with REMS requirements.
   vi. Ensure that certified prescribers are provided access to the database of certified pharmacies and enrolled patients.
   vii. Provide the SILIQ REMS Program Prescriber Enrollment Form, SILIQ REMS Program Patient-Prescriber Agreement Form, SILIQ REMS Program Patient Wallet Card, and the Prescribing Information to prescribers who (1) attempt to prescribe SILIQ and are not yet certified, or (2) inquire about how to become certified.

The following materials are part of the REMS and are appended:

- SILIQ REMS Program Prescriber Enrollment Form
- SILIQ REMS Program Patient-Prescriber Agreement Form
- SILIQ REMS Program Patient Wallet Card

2. Pharmacies that dispense SILIQ must be certified.
   a. To become certified to dispense SILIQ, pharmacies must:
      i. Designate an authorized representative to complete the enrollment process by submitting the completed SILIQ REMS Program Pharmacy Enrollment Form on behalf of the pharmacy.
      ii. Ensure that the authorized representative oversees implementation and compliance with the SILIQ REMS Program requirements by the following:
          1) Review and complete the SILIQ REMS Program Pharmacy Enrollment Form.
          2) Ensure all relevant staff involved in the dispensing of SILIQ are informed of the SILIQ REMS Program requirements as described in the SILIQ REMS Program Pharmacy Enrollment Form.
          3) Put processes and procedures in place to ensure the following requirements are completed prior to dispensing SILIQ:
a) Verify the prescriber is certified and the patient is enrolled in the SILIQ REMS Program by calling the SILIQ REMS Program or by accessing the SILIQ REMS Program Website.

b. As a condition of certification, the certified pharmacies must:
   i. Recertify in the SILIQ REMS Program if the pharmacy designates a new authorized representative.
   ii. Dispense SILIQ to patients only after obtaining authorization by calling the SILIQ REMS Program or by accessing the SILIQ REMS Program Website. The authorization confirms the following:
       1) The prescriber is certified in the SILIQ REMS Program; and
       2) The patient is enrolled in the SILIQ REMS Program.
   iii. Maintain documentation that all processes and procedures are in place and are being followed for the SILIQ REMS Program and provide upon request to Bausch Health, FDA, or a third party acting on behalf of Bausch Health or FDA.
   iv. Comply with audits by Bausch Health, FDA, or a third party acting on behalf of Bausch Health or FDA, to ensure that all processes and procedures are in place and are being followed for the SILIQ REMS Program.

c. Bausch Health must:
   i. Ensure that pharmacies that dispense SILIQ are specially certified, in accordance with the requirements described above.
   ii. Provide all the following mechanisms for pharmacies to complete certification for the SILIQ REMS Program: online, by email, and by fax.
   iii. Ensure that pharmacies are notified when they have been certified by the SILIQ REMS Program.
   iv. Ensure that certified pharmacies are provided access to the database of certified prescribers and enrolled patients.
   v. Verify every year that the authorized representative’s name and contact information correspond to those of the currently designated authorized representative for the certified pharmacy. If different, the pharmacy must be required to recertify with a new authorized representative.

The following materials are part of the REMS and are appended:
   • SILIQ REMS Program Pharmacy Enrollment Form
   • SILIQ REMS Program Website (www.SILIQREMS.com)

3. SILIQ must be dispensed to patients with evidence or other documentation of safe-use conditions.
   a. To become enrolled in the SILIQ REMS Program, a patient must sign a SILIQ REMS Program Patient-Prescriber Agreement Form indicating that he/she has:
      i. Received and has read the SILIQ REMS Program Patient-Prescriber Agreement Form with their prescriber.
      ii. Received counseling from the prescriber regarding:
          1) the observed risk of suicidal ideation and behavior (SIB)
          2) the importance of keeping the SILIQ REMS Program Patient Wallet Card with them at all times

   3
3) the need to seek medical attention should they experience emergence or worsening of suicidal ideation and behavior

iii. Received the SILIQ REMS Program Patient Wallet Card

b. Bausch Health must:
   i. Provide all of the following mechanisms for the certified prescribers to be able to submit the completed SILIQ REMS Program Patient-Prescriber Agreement Form to the SILIQ REMS Program: online, by email, and by fax.

The following materials are part of the REMS and are appended:
   - SILIQ REMS Program Patient Wallet Card
   - SILIQ REMS Program Patient-Prescriber Agreement Form

B. Implementation System

1. Bausch Health must ensure that SILIQ is only distributed to certified pharmacies by:
   a. Ensuring that wholesalers/distributors who distribute SILIQ comply with the program requirements for wholesalers/distributors. The wholesalers/distributor must:
      i. Put processes and procedures in place to verify, prior to distributing SILIQ, that the pharmacies are certified.
      ii. Train all relevant staff on the SILIQ REMS Program requirements.
      iii. Comply with audits by Bausch Health, FDA, or a third party acting on behalf of Bausch Health or FDA to ensure that all processes and procedures are in place and are being followed for the SILIQ REMS Program. In addition, wholesalers/distributors must maintain documentation to support that all processes and procedures are in place, being followed, and make the documentation available for audits.
      iv. Provide distribution data to Bausch Health to verify compliance with the REMS.
   b. Ensuring that wholesalers/distributors maintain distribution records of all shipments of SILIQ and provide the data to Bausch Health.

2. Bausch Health must monitor distribution data to ensure all the processes and procedures are in place and functioning to support the requirements of the SILIQ REMS Program.

3. Bausch Health must audit the wholesalers/distributors within 90 calendar days after the wholesaler/distributor is authorized to ensure that all processes and procedures are in place and functioning to support the requirements of the SILIQ REMS Program.

4. Bausch Health must maintain a validated, secure database of prescribers and pharmacies that are certified to dispense SILIQ in the SILIQ REMS Program. Bausch Health will make the list of certified prescribers available to patients via the SILIQ REMS Program Website (www.SILIQREMS.com).

5. Bausch Health must maintain a validated, secure database of patients who are enrolled in the SILIQ REMS Program.

6. Bausch Health must maintain records of SILIQ certified prescribers, certified pharmacies, and enrolled patients to meet REMS requirements.

7. Bausch Health must maintain a SILIQ REMS Program Call Center (855-511-6135) and SILIQ REMS
Program Website (www.SILIQREMS.com). The SILIQ REMS Program Website must include the capability to confirm patient authorization status, and the option to print the Prescribing Information, Medication Guide, and SILIQ REMS materials. The SILIQ product website must include a prominent REMS-specific link to the SILIQ REMS Program Website. The SILIQ REMS Program Website must not link back to the product website(s).

8. Bausch Health must ensure that the SILIQ REMS Program Website is fully operational, including the capability to complete prescriber and pharmacy certification and patient enrollment online; online confirmation of patient authorization functionality; and the REMS materials listed in or appended to the SILIQ REMS document are available through the SILIQ REMS Program Website and by calling the SILIQ REMS Program Call Center.

9. Bausch Health must monitor on an ongoing basis the certified pharmacies to ensure the requirements of the SILIQ REMS Program are being met. Bausch Health must institute corrective action if noncompliance is identified and decertify pharmacies that do not maintain compliance with the REMS requirements.

10. Bausch Health must maintain an ongoing annual audit plan that involves certified pharmacies.

11. Bausch Health must audit 20% or one, whichever is greater, of the certified pharmacies within 90 calendar days after the pharmacy places its first order of SILIQ to ensure that all processes and procedures are in place and functioning to support the requirements of the SILIQ REMS Program. The certified pharmacies must be identified in Bausch Health’s ongoing annual audit plan. Bausch Health must institute corrective action if noncompliance is identified.

12. Bausch Health must take reasonable steps to improve implementation of and compliance with the requirements in the SILIQ REMS Program based on monitoring and evaluation of the SILIQ REMS Program.

III. TIMETABLE FOR SUBMISSION OF ASSESSMENTS

Bausch Health must submit REMS assessments to the FDA at 6 months and 12 months and annually thereafter from the date of the initial approval of the REMS (February 15, 2017). To facilitate inclusion of as much information as possible while allowing reasonable time to prepare the submission, the reporting interval covered by each assessment should conclude no earlier than 60 calendar days before the submission date for that assessment. Bausch Health must submit each assessment so that it will be received by the FDA on or before the due date.
 Instructions

Please fax this completed form to the SILIQ Risk Evaluation Mitigation Strategy (REMS) Program at 1-866-227-9451, submit online at www.SILIQREMS.com, or email it to SILIQ@SILIQREMS.com.

SILIQ (brodalumab) is available only through the SILIQ REMS Program. The SILIQ REMS Program is available to answer questions regarding this program and initiating treatment with SILIQ. Please call 1-855-511-6135 for more information.

Only prescribers, pharmacies, and patients enrolled in the SILIQ REMS Program are able to prescribe, dispense and receive SILIQ.

1. Review the one-time SILIQ REMS Enrollment Information for Prescribers, including the Prescribing Information (PI).
2. Complete and submit this SILIQ REMS Program Prescriber Enrollment Form via the program website, email, or the fax number provided.
3. Send your patient’s prescription to a pharmacy that is enrolled in the SILIQ REMS Program by utilizing the Pharmacy Certification Look Up function on the SILIQ REMS Program website.

You will receive enrollment confirmation via your preferred method of communication (email or fax) within 2 business days.

### SILIQ Prescriber Information (*Required*)

<table>
<thead>
<tr>
<th>First Name:*</th>
<th>Last Name:*</th>
<th>Degree*:</th>
<th>MD</th>
<th>DO</th>
<th>PA</th>
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</table>

### Prescriber Agreement

By completing this form, I attest that:

1. I have read and understand the SILIQ Prescribing Information.
2. I understand that I must comply with the Program requirements in order to prescribe SILIQ.
3. I understand that by signing this SILIQ REMS Program Prescriber Enrollment Form (one time only), I will be enrolled in the SILIQ REMS Program and may prescribe SILIQ.
4. I understand that, prior to authorizing the first prescription, I am responsible for counseling each patient that suicidal ideation and behavior (SIB), including completed suicides, have occurred in patients treated with SILIQ. I will inform the patient of the following key safety information:
   - Suicidal ideation and behavior (SIB) events and symptoms may occur at any time during treatment with SILIQ.
   - To be aware of symptoms of suicidal ideation behavior (SIB) events and steps to take if SIB symptoms occur.
5. I understand that I must submit a completed SILIQ REMS Program Patient-Prescriber Agreement Form for each patient before I prescribe SILIQ for the first time, and store a copy of the completed form in the patient’s record.
6. I will provide each patient with a SILIQ REMS Program Patient Wallet Card and instruct each patient to carry this card with them at all times.
7. I understand that patients with new or worsening symptoms of depression or suicidality should be referred to a mental health professional, as appropriate.
8. I will inform the SILIQ REMS Program if an enrolled patient has discontinued therapy or is no longer under my care.
9. I understand Bausch Health and its agents may contact me via phone, mail, fax, email, or in person to support administration of the SILIQ REMS Program.

Prescriber Signature*: Date*:

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Instructions for Prescribers

1. Sign this form along with your patient and place it in the patient’s chart.
2. Tear off the bottom portion and provide it to your patient to take home as a reference.
3. Submit this completed form to the SILIQ Risk Evaluation and Mitigation Strategy (REMS) Program online at [www.SILIQREMS.com](http://www.SILIQREMS.com) or by fax at 1-866-227-9451.

**Patient Acknowledgement** (*Required*)

By signing this form, I acknowledge that:

- [ ] I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ.
- [ ] I will call my doctor or the National Suicide Prevention Lifeline at 1-800-273-8255 if:
  - [ ] I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning.
  - [ ] I am thinking about hurting or killing myself; seeking access to firearms, pills or other means for the purpose of self-harm; or am talking or writing about death and dying.
- [ ] I will **call 911** if I feel an immediate threat of death or self-injury.
- [ ] My doctor has given me a SILIQ REMS Patient Wallet Card to carry with me at all times.

**Printed First and Last Name**:  
**Date of Birth (Month/Day/Year)**:  
**Address**:  
**City**:  
**State**:  
**Zip Code**:  
**Race**:  
[ ] African American  
[ ] Asian  
[ ] Caucasian  
[ ] Hispanic  
[ ] Other  
**Phone Number**:  
**Patient Signature**:  
**Date**:  

**Prescriber Acknowledgement**

I acknowledge that prior to prescribing SILIQ:

- [ ] I have counseled my patient about the importance of seeking medical advice should signs of suicidal ideation or behavior, new onset or worsening depression, anxiety, or other mood changes emerge.
- [ ] I have evaluated the risks and benefits of continuing treatment with SILIQ if such events occur.

**Printed First and Last Name**:  
**Phone Number**:  
**DEA**:  
**NPI**:  
**Prescriber Signature**:  
**Date**:  

---

**SILIQ Patient Information**

- I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ.
- I will call my doctor or the National Suicide Prevention Lifeline at 1-800-273-8255 if:
  - I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning.
  - I am thinking about hurting or killing myself; seeking access to firearms, pills or other means for the purpose of self-harm; or am talking or writing about death and dying.
- I will **call 911** if I feel an immediate threat of death or self-injury.

For more information about the SILIQ REMS Program please visit [www.SILIQREMS.com](http://www.SILIQREMS.com)

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SILIQ™ REMS Program
Patient Wallet Card

SILIQ is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies.

**WARNING: Suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ.**

Taking SILIQ has proven effective for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy. However, if you are experiencing sudden feelings of withdrawal, anxiety, depression or hopelessness, call your doctor immediately. Suicide warning signs also include thinking about hurting or killing yourself; seeking access to firearms, pills or other means for the purpose of self-harm; and talking or writing about death and dying when these actions are out of the ordinary.¹,²
You are not alone. Help is available.

I will call my doctor or the **National Suicide Prevention Lifeline at 1-800-273-8255 (TALK)** if:

- I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning.
- I am thinking about hurting or killing myself; seeking access to firearms, pills or other means for the purpose of self-harm; or am talking or writing about death and dying$^2$.

I will call **911** if I feel an immediate threat of death or self-injury.

Learn about the signs of suicide at [www.suicidelifeline.org](http://www.suicidelifeline.org).

For more information, visit [www.SILIQREMS.com](http://www.SILIQREMS.com) or call 1-855-511-6135.

$^1$ American Association of Suicidology. Know the Warning Signs of Suicide. [http://www.suicidology.org/resources/warning-signs](http://www.suicidology.org/resources/warning-signs).

Instructions

To become enrolled, the pharmacy must designate an Authorized Pharmacy Representative to ensure compliance with the SILIQ Risk Evaluation and Mitigation Strategy (REMS) Program.

Please fax this completed form to the SILIQ REMS Program at 1-866-227-9451, submit online at www.SILIQREMS.com, or email it to SILIQ@SILIQREMS.com.

SILIQ (brodalumab) is available only through the SILIQ REMS Program. The SILIQ REMS Program is available to answer questions regarding this program and initiating treatment with SILIQ. Please call 1-855-511-6135 for more information.

Authorized Pharmacy Representative Responsibilities

I am the authorized representative designated by my pharmacy to coordinate the activities of the SILIQ REMS Program. By signing this form, I agree, on behalf of myself and my pharmacy, to comply with the following program requirements:

1. I understand that by signing this form, and upon confirmation from the SILIQ REMS Program, this pharmacy will be enrolled in the SILIQ REMS Program, and will be able to order and dispense SILIQ.

2. This pharmacy will re-enroll in the SILIQ REMS Program if the name and contact information for the Authorized Pharmacy Representative changes.

3. This pharmacy will ensure that all relevant staff involved in the dispensing of SILIQ is trained on the SILIQ REMS Program requirements.

4. This pharmacy will maintain and make available appropriate documentation reflecting that all processes and procedures are in place and being followed.

5. I understand that non-compliance with the requirements of the SILIQ REMS Program will result in decertification of my pharmacy and termination of authorization to dispense SILIQ.

6. I will ensure that, prior to dispensing SILIQ, my pharmacy will verify that the prescriber is certified and the patient is enrolled to receive SILIQ by contacting the SILIQ REMS Program.

7. This pharmacy will comply with audits by Bausch Health, the US Food and Drug Administration (FDA), or a designated third party acting on behalf of Bausch Health or FDA to ensure compliance with the SILIQ REMS Program.

Pharmacy Information (*Required)

<table>
<thead>
<tr>
<th>Pharmacy Name*:</th>
<th>Pharmacy Type*:</th>
<th>☐ Inpatient ☐ Outpatient</th>
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<tr>
<td>Address*:</td>
<td>City*:</td>
<td>State*:</td>
</tr>
<tr>
<td>NPI*:</td>
<td>NCPDP*:</td>
<td>DEA*:</td>
</tr>
<tr>
<td>Pharmacy Identifier* (at least one required):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authorized Pharmacy Representative Information (*Required)

<table>
<thead>
<tr>
<th>First Name*:</th>
<th>Last Name*:</th>
<th>MI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number*:</td>
<td>Alternate Telephone Number:</td>
<td>Office Fax*:</td>
</tr>
<tr>
<td>Email*:</td>
<td>Preferred Method of Communication*: ☐ Email ☐ Fax</td>
<td></td>
</tr>
</tbody>
</table>

Authorized Pharmacy Representative Signature*: Date*:

By completing and submitting this form and receiving enrollment confirmation, your pharmacy will be certified in the SILIQ REMS Program. You will receive confirmation of your enrollment via your preferred method of communication.

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SILIQ REMS Program
Website Screen Captures

April 10, 2019
Version 10.0
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1. General Pages

1.1 Home Page

What is the SILIQ REMS Program?
A Risk Evaluation and Mitigation Strategy (REMS) is a strategy to manage known or potential serious risks associated with a drug product, and is required by the FDA to ensure the benefits of a drug outweigh its risks.

The goal of the SILIQ REMS Program is to mitigate the observed risk of suicidal ideation and behavior, including completed suicides, which occurred in subjects treated with SILIQ by:

- Ensuring that prescribers are educated about the risk of suicidal ideation and behavior observed with SILIQ therapy and the need to counsel patients about this risk.
- Ensuring that patients are informed about the potential risk of suicidal ideation and behavior observed with SILIQ therapy and the need to seek medical attention for manifestations of suicidal thoughts and behavior, new onset or worsening depression, anxiety, or other mood changes.

Materials for Prescribers
- SILIQ REMS Program Prescriber Enrollment Form
- SILIQ REMS Program Patient-Physician Agreement Form
- SILIQ REMS Program Patient-Physician Agreement Form (Spanish)
- SILIQ Prescribing Information

Materials for Pharmacies
- SILIQ REMS Program Pharmacy Enrollment Form

Materials for Patients
- SILIQ REMS Program Patient-Physician Agreement Form
- SILIQ REMS Program Patient-Physician Agreement Form (Spanish)
- SILIQ REMS Program Patient Wallet Card
- SILIQ REMS Program Patient Wallet Card (Spanish)
1.2 Prescriber Landing Page

Prescriber Certification

Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ.

To complete prescriber certification:

READ the SILIQ REMS Program Prescribing Information, to understand the risks of SILIQ and to learn about the SILIQ REMS Program

COMPLETE a SILIQ REMS Program Prescriber Enrollment Form

To complete enrollment for SILIQ patients:

EDUCATE & COUNSEL all patients about the risks of SILIQ and how to monitor them.

SIGN a SILIQ REMS Program Patient-Prescriber Agreement Form for each new patient before prescribing SILIQ and submit the completed form to the SILIQ REMS Program and store a copy in the patient's records.

Materials for Prescribers
- SILIQ REMS Program Prescriber Enrollment Form
- SILIQ REMS Program Patient-Prescriber Agreement Form
- SILIQ REMS Program Patient-Prescriber Agreement Form (Spanish)
- SILIQ Prescribing Information

Materials for Patients
- SILIQ REMS Program Patient-Prescriber Agreement Form
- SILIQ REMS Program Patient-Prescriber Agreement Form (Spanish)
- SILIQ REMS Program Patient Wallet Card
- SILIQ REMS Program Patient Wallet Card (Spanish)
1.3 Pharmacy Landing Page

Pharmacy Certification

All pharmacies must certify in the SILIQ REMS Program to purchase and dispense SILIQ.

To become certified, pharmacies must designate an authorized representative to complete certification. In general, an authorized representative for a pharmacy:

- Coordinates the activities required for the pharmacy in the SILIQ REMS Program
- Establishes and implements processes and procedures to ensure compliance with the safe use conditions of the SILIQ REMS Program

The authorized representative for each pharmacy must complete the following steps to certify in the SILIQ REMS Program:

READ the SILIQ Prescribing Information to understand the risks of SILIQ and to learn about the SILIQ REMS Program
CERTIFY by completing and submitting the SILIQ REMS Program Pharmacy Enrollment Form

Start Pharmacy Certification
1.4 Patient Landing Page

Patient’s Role in the SILIQ REMS Program:

Only patients who are enrolled and counseled on the safe use of SILIQ by their prescriber should be prescribed SILIQ. Patients will be counseled on the SILIQ REMS Program by certified prescribers. Patients will have the opportunity to discuss any questions or concerns they have with their prescriber. The prescriber will provide and review the SILIQ REMS Program Patient-Prescriber Agreement Form.
## 1.5 Pharmacy Staff Landing Page

### Prescribers, Pharmacies, Patients

<table>
<thead>
<tr>
<th>Pharmacy Staff</th>
<th>Pharmacies</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steps for Pharmacy Staff Enrollment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy staff may include pharmacists or other individuals who assist in dispensing SILIQ. If your pharmacy is certified to dispense SILIQ, pharmacy staff can enroll in the SILIQ REMS Program to have access to the SILIQ REMS Program Website. Pharmacy staff can associate to one or more pharmacy locations.</td>
<td>Pharmacy Certification</td>
<td></td>
</tr>
<tr>
<td>Pharmacy staff must complete the following steps to enroll in the SILIQ REMS Program:</td>
<td>Certified Pharmacies</td>
<td></td>
</tr>
<tr>
<td>1. Create an online account</td>
<td>Pharmacy Staff Enrollment</td>
<td></td>
</tr>
<tr>
<td>2. Associate to a Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Certify by completing and submitting the pharmacy staff member information and attestation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Start Pharmacy Staff Enrollment**

---

**Contact Information**

Email: SILIQ@SILIQREMS.com  
Phone: 651-511-8135  
Fax: 662-227-9451
1.6 Site Map

Site Map

Prescribers

Prescriber

Prescriber Certification

Pharmacy

Pharmacy Certification

Patient

Patient Information

General

Contact Us

Prescribing Information

Privacy

Terms of Use

Account

Forgot Password

Forgot Username

Need an Account

Email: SILIQ@SILIQREMSI.com
Phone: 855-511-6136
Fax: 855-227-9451
1.7 Prescriber Search Page – with results

User Search

If you began or completed certification through a fax process, you may already be certified in the SILIQ REMS Program. To determine your certification status, please complete the fields below and press Search. If you are a New User, please click here. All fields listed below are required unless otherwise indicated.

At least one identifier is required

<table>
<thead>
<tr>
<th>NPI</th>
<th>DEA (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Certification ID (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
<th>Email (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Search

If the search results have returned your record, please highlight the row and press Submit. If you do not see your record, you can either try your search again or press the New User button to begin your certification process in the SILIQ REMS Program.

Showing 1 to 1 of 1 entries

1 » 10

New User Submit

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6135
Fax: 866-227-9451
1.8 Prescriber Search Page – with no results found

User Search

If you began or completed certification through a fax process, you may already be certified in the Siliq REMS Program. To determine your certification status, please complete the fields below and press Search. If you are a New User, please click here. All fields listed below are required unless otherwise indicated.

At least one identifier is required

<table>
<thead>
<tr>
<th>NPI</th>
<th>DEA (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Certification ID (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
<th>Email (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Search

No results found. Please try your search again or contact the Siliq REMS Program for assistance. Alternatively, You may also use the New User button below to begin your certification process in the Siliq REMS Program.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Showing 0 to 5 of 0 entries

1 to 10

New User

Email: Siliq@SiliqREMS.com
Phone: 855-511-6135
Fax: 855-227-9451
1.9 Pharmacy Search Page – with results

User Search

If you began or completed certification through a fax process, you may already be certified in the SILIQ REMS Program. To determine your certification status, please complete the fields below and press Search. If you are a New User, please click here. All fields listed below are required unless otherwise indicated.

Pharmacy Information (at least one identifier is required):

- Zip Code
- DEA
- NPI Number
- NCPDP Number
- First Name
- Last Name
- Certification ID (Optional)
- Phone
- Fax
- Email (Optional)

If the search results have returned your record, please highlight the row and press Submit. If you do not see your record, you can either try your search again or press the New User button to begin your certification process in the SILIQ REMS Program.
1.10 Pharmacy Search Page – with no results found

User Search

If you began or completed certification through a fax process, you may already be certified in the SILIQ REMS Program. To determine your certification status, please complete the fields below and press Search. If you are a New User, please click here. All fields listed below are required unless otherwise indicated.

Pharmacy Information (at least one identifier is required):

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>DEA</th>
<th>NPI Number</th>
<th>NCPDP Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Certification ID (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
<th>Email (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Search

No results found. Please try your search again or contact the SILIQ REMS Program for assistance. Alternatively, you may use the New User button below to begin your certification process in the SILIQ REMS Program.

New User

Showing 0 to 0 of 0 entries

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6136
Fax: 866-227-9451

Contact Us | Privacy Policy | Terms and Conditions | Site Map
1.11 Account Registration Page

Create an Account

To create your web account for the SILIQ REMS Program, please complete the fields below. The Username you specify must be unique within the SILIQ REMS Program website. Once you have submitted this form you will receive a verification email that includes a link. Please use the link to complete the activation process for your new web account. All fields below are required unless otherwise indicated.

- **First Name**
- **Last Name**
- **Email Address**
- **Confirm Email Address**
- **Phone Number**
- **Username**
- **Password**
- **Confirm Password**

Options:
- **Use Email Address as Username**
- **Suggest Username**
- **I'm not a robot**

[Submit] [Cancel]
## 1.12 Certified Pharmacies

The SILIQ REMS Certified Pharmacy Network list includes pharmacies that can dispense the SILIQ REMS Product. All pharmacies listed are certified to dispense SILIQ.

### Table: Certified Pharmacies

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Certification ID</th>
<th>Pharmacy Address</th>
<th>Pharmacy Phone</th>
<th>Pharmacy Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uptown Drugs</td>
<td>FAC96876655</td>
<td>5228 N Roxie Drive DURHAM North Carolina 27704</td>
<td>919-333-7325</td>
<td>555-555-5555</td>
</tr>
</tbody>
</table>

Showing 1 to 2 of 2 entries
1.13 Forgot Username

Forgot Username

Please enter your First Name, Last Name and Email Address in the spaces provided below. Your username will be sent to the email you registered with the SILIQ REMS Program.

First Name
Last Name
Email Address

Submit
1.14 Forgot Password

Forgot Password

Please enter your username and email address in the spaces provided below. Your username is the identification you established when creating your web account for the SILIQ REMS Program.

Username

Email Address

Submit
1.15 Contact Us

If you have any questions or require additional information, please contact the SILIQ REMS Program utilizing the information provided below.

Phone Number
855-511-6135

Fax Number
866-227-9451

Email Address
SILIQ@SILIQREMS.com

Mailing Address
SILIQ REMS Program
PO Box 52170
Phoenix, AZ 85072

Program Manufacturer
Bausch Health US, LLC
2. Prescriber Online Certification

2.1 Prescriber Information Page
2.2 Prescriber Attestation Page

Prescriber Attestation

To complete the prescriber certification for John Smith into the SILIQ REMS Program online, please review the attestation section below to provide your acknowledgement along with signature and signature date.

Alternatively, you may print your online enrollment form using the print icon to the right and fax it to the SILIQ REMS Program at 866-227-9451.

As a prescriber, I attest that:

1. I have read and understand the SILIQ Prescribing Information.
2. I understand that I must comply with the Program requirements in order to prescribe SILIQ.
3. I understand that by signing this SILIQ REMS Program Prescriber Enrollment Form (one time only), I will be enrolled in the SILIQ REMS Program and may prescribe SILIQ.
4. I understand that, prior to authorizing the first prescription, I am responsible for counseling each patient that suicidal ideation and behavior (SIB), including completed suicides, have occurred in patients treated with SILIQ. I will inform the patient of the following key safety information:
   - Suicidal ideation and behavior (SIB) events and symptoms may occur at any time during treatment with SILIQ.
   - To be aware of symptoms of suicidal ideation and behavior (SIB) events and steps to take if SIB symptoms occur.
5. I understand that I must submit a completed SILIQ REMS Program Patient-Prescriber Agreement Form for each patient before I prescribe SILIQ for the first time, and store a copy of the completed form in the patient's record.
6. I will provide each patient with a SILIQ REMS Program Patient Wallet Card and instruct each patient to carry this card with them at all times.
7. I understand that patients with new or worsening symptoms of depression or suicidality should be referred to a mental health professional, as appropriate.
8. I will inform the SILIQ REMS Program if an enrolled patient has discontinued therapy or is no longer under my care.
9. I understand Bausch Health and its agents may contact me via phone, mail, fax, email, or in person to support administration of the SILIQ REMS Program.

☐ By checking this box, I agree to comply with the SILIQ REMS Program requirements.

Signature

Signature Date

Back Submit
2.3 Prescriber Confirmation Page

Prescriber Certification Confirmation

You are now certified in the SILIQ REMS Program.

Below is your SILIQ REMS Program Certification ID. Please retain this information for your records.

Certification ID: HCP123456879

Email: SILIQ@SILIQREMS.com
Phone: 866-511-6136
Fax: 866-227-9451
3. Pharmacy Online Certification

3.1 Authorized Representative Information Page

Authorized Representative Intake
To begin the process as an authorized representative in the SILIQ REMS Program, please complete the required fields below and press Next. All fields listed below are required unless otherwise indicated.

Authorized Pharmacy Representative Information

First Name
Last Name
Email Address
Confirm Email Address
Telephone Number
Alternate Telephone Number (Optional)
Office Fax
Preferred Method of Communication -- Please Select --

Cancel  Next
3.2 Authorized Representative Confirmation Page

Authorized Representative Confirmation

You are now an authorized representative in the SILIQ REMS Program.

If you are ready to certify your pharmacy now please use Certify Pharmacy. To return to your dashboard for other activities, please use the My Dashboard button at the top of the page. If you have completed your session today, simply close your browser.

Email: SILIQ@SILIQREMS.com
Phone: 866-511-6135
Fax: 866-227-9451

Contact Us | Privacy Policy | Terms and Conditions | Site Map
3.3 Pharmacy Information Page

Pharmacy Intake
To certify your pharmacy, please complete the required fields below and press Next. Once certified, you will receive a certification confirmation via the contact preference you selected during your authorized representative intake. All fields listed below are required unless otherwise indicated.

Pharmacy Information
- **Pharmacy Name**
- **Pharmacy Type**
- **Address**
- **City**
- **State**
- **Zip Code**

Pharmacy Identifiers
- **DEA Number**
- **NPI Number**
- **NCQPP Number**

[Next] [Cancel]
3.4 Pharmacy Attestation Page

Pharmacy Attestation

To complete the Pharmacy Certification for ABC Pharmacy into the SILIQ REMS Program, please review the attestation section below to provide your acknowledgement along with signature and signature date.

Alternatively, you may print this form by clicking the icon on the right and fax it to the SILIQ REMS Program at 866-227-3451.

I am the authorized representative designated by my pharmacy to coordinate the activities of the SILIQ REMS Program. By signing this form, I agree, on behalf of myself and my pharmacy, to comply with the following program requirements:

1. I understand that by signing this form, and upon confirmation from the SILIQ REMS Program, this pharmacy will be enrolled in the SILIQ REMS Program, and will be able to order and dispense SILIQ.
2. This pharmacy will re-enroll in the SILIQ REMS Program if the name and contact information for the Authorized Pharmacy Representative(s) changes.
3. This pharmacy will ensure that all relevant staff involved in the dispensing of SILIQ is trained on the SILIQ REMS Program requirements.
4. This pharmacy will maintain and make available appropriate documentation reflecting that all processes and procedures are in place and being followed.
5. I understand that non-compliance with the requirements of the SILIQ REMS Program will result in de-enrollment from the program and termination of authorization to dispense SILIQ.
6. I will ensure that, prior to dispensing SILIQ, my pharmacy will verify that the prescriber is certified and the patient is enrolled to receive SILIQ by contacting the SILIQ REMS Program.
7. This pharmacy will comply with audits by Bausch Health, the U.S. Food and Drug Administration (FDA), or a designated third party acting on behalf of Bausch Health or FDA to ensure compliance with the SILIQ REMS Program.

☐ By checking this box, I agree, on behalf of myself and my pharmacy, to comply with the SILIQ REMS Program requirements.

Signature

Signature Date

Back Submit
3.5 Pharmacy Confirmation Page

Pharmacy Certification Confirmation

Your pharmacy is now certified in the SILIQ REMS Program

Below is your SILIQ REMS Program Certification ID. Please retain this information for your records.

Certification ID: FAC123456789

To add additional pharmacies or manage your pharmacies, please use the My Dashboard button at the top of the page.
3.6 Pharmacy Staff Information Page

Pharmacy Staff Intake

To enroll as a pharmacy staff member please complete the form below and select the Next button. Once enrolled, you will receive an enrollment confirmation via your preferred method of contact. All fields are required unless otherwise indicated.

Pharmacy Staff Information

- First Name
- Last Name
- Email Address
- Confirm Email Address
- Telephone Number
- Alternate Telephone Number (Optional)
- Fax
- Preferred Method of Communication (Optional)

[Buttons: Cancel, Next]
3.7 Pharmacy Staff Attestation Page

Pharmacy Staff Attestation

To complete pharmacy staff enrollment in the SILIQ REMS Program, please review the attestation section below to provide an acknowledgement along with signature and signature date.

As a pharmacy staff member:
1. I attest that I have been trained and will follow the requirements of the SILIQ REMS Program.
2. I understand I can access the SILIQ REMS Program Website to:
   • Verify the prescriber is certified and the patient is enrolled, prior to the patient receiving SILIQ
   • Edit my profile information
   • Associate my profile to one or more pharmacies
   • Disassociate my profile from one or more pharmacies

☐ By checking this box, I agree to comply with the SILIQ REMS Program requirements.

Signature

Signature Date
3.8 Pharmacy Staff Confirmation Page

Pharmacy Staff Confirmation

You are now an enrolled pharmacy staff member in the SILIQ REMS Program.

Below is your SILIQ REMS Program Enrollment ID. Please retain this information for your records.

Enrollment ID: <Enrollment ID>

Print

To add additional pharmacies or manage your pharmacies, please use the My Dashboard button at the top of the page.
4. Patient Online Enrollment

4.1 Patient Acknowledgement Page

Patient Acknowledgement

To enroll your patient into the SILIQ REMS Program, please complete the required fields below with the patient and press Next. Once the patient enrollment is complete, you will receive an enrollment confirmation via fax.

**Patient Information** (all fields required)

- **First Name:** 
- **Last Name:** 
- **Date of Birth:** MM/DD/YYYY
- **Phone Number:** 
- **Race:** — Please Select —
- **Address:** 
- **City:** 
- **State:** — Please Select —
- **Zip Code:**

By signing this form, I acknowledge that:

- I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ.
- I will call my doctor or the National Suicide Prevention Lifeline at 1-800-273-TALK(8255) if:
  - I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning.
  - I am thinking about hurting or killing myself, seeking access to firearms, pills or other means for the purpose of self-harm; or am taking or writing about death and dying.
- I will call 911 if I feel an immediate threat of death or self-injury.
- My doctor has given me a SILIQ REMS Program Patient Wallet Card to carry with me at all times.

**Patient Signature**

Please enter your name as your electronic signature

[Signature Date]

[ ] Cancel  [ ] Next
4.2 Prescriber Acknowledgment Page

Prescriber Acknowledgement

I acknowledge that prior to prescribing SILIQ:

☐ I have counseled my patient about the importance of seeking medical advice should signs of suicidal ideation or behavior, new onset or worsening depression, anxiety, or other mood changes emerge.

☐ I have evaluated the risks and benefits of continuing treatment with SILIQ if such events occur.

Prescriber Signature

Signature Date

Please enter your name as your electronic signature

Back  Submit
### 4.3 Patient Enrollment Confirmation Page

#### Patient Enrollment Confirmation

- Your patient is now enrolled in the SILIQ REMS Program.

Please print this information and tear off the bottom portion of the printed SILIQ REMS Program Patient-Prescriber Agreement Form and provide it to your patient to take home as a reference. You are responsible to retain this information for your records.

**Enrollment ID: PAT123456789**

---

**Email:** SILIQ@SILIQREMS.com  
**Phone:** 866-511-6135  
**Fax:** 866-227-9451
5. Dashboard

5.1 Prescriber Dashboard
5.2 Manage Patient Status

Manage Patient Status

Updating the patient status will deactivate the patient from the SILIQ REMS Program. The patient will no longer be eligible to receive SILIQ. The patient will no longer appear on the prescriber dashboard. To continue please select an option below and press Submit.

First Name: John
Last Name: Smith
Date of Birth: 02/02/1954
Zip Code: 10001
Update Patient Status: -- Please Select --

[Cancel] [Submit]
5.3 View Patient Profile

Patient Profile

Patient Information

First Name: John
Last Name: Smith
Date of Birth: 05/02/1962
Phone: 555-555-0011
State: New York
Zip Code: 10001

Patient Enrollment Information

Enrollment ID: PAT123456789

Cancel  Save
5.4 Pharmacy Dashboard

Pharmacy Dashboard

Please search for your pharmacy in the table below and take the appropriate action. If you need to add a new pharmacy to your list, please use the Add Pharmacy button. For taking actions, use the Actions list. Actions available are View Pharmacy Profile and Request Prescience Authorization.

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Address</th>
<th>Pharmacy Type</th>
<th>Certification ID</th>
<th>Status</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>1234 West Pharmacy Lane Phoenix AZ 80000</td>
<td>Inpatient</td>
<td>FAC1000000000</td>
<td>Certified</td>
<td>Please Select ▼ Go</td>
</tr>
<tr>
<td>XYZ Pharmacy</td>
<td>15 East Prescription Street Phoenix AZ 89300</td>
<td>Outpatient</td>
<td>FAC1000000000</td>
<td>Certified</td>
<td>Please Select ▼ Go</td>
</tr>
</tbody>
</table>

Showing 1 to 2 of 2 entries

1 » 10 ▼
5.5 Edit Authorized Pharmacy Representative Profile

My Profile

My Information

First Name: John
Last Name: Doe
Email Address: john.doe@email.com
Telephone Number: 655-555-5555
Alternate Telephone Number (Optional): 555-555-4444
Office Fax: 555-555-0000
Preferred Method of Communication: Email

Edit
5.6 View Pharmacy Profile

Pharmacy Profile

Pharmacy Information

Pharmacy Name: Pharmacy ABC
Pharmacy Type: Inpatient Pharmacy
Address: 1 Main Street
City: New York
State: New York
Zip Code: 10001

Pharmacy Identifiers

DEA Number: AB23423412
NPI Number: 23423423423
NCPDP Number: 123546575

Pharmacy Certification

Certification ID: FAC123456789 🥰
5.7 Pharmacy Staff Dashboard

My Dashboard
The table below contains all of your associated pharmacies. If you need to associate yourself to a new pharmacy, use the Associate to Pharmacy button. For taking actions, use the Actions list.

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Address</th>
<th>Pharmacy Type</th>
<th>Status</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>1234 West Pharmacy Lane Phoenix AZ 85008</td>
<td>Inpatient</td>
<td>Certified</td>
<td>Please Select</td>
</tr>
<tr>
<td>XYZ Pharmacy</td>
<td>15 East Prescription Street Phoenix AZ 85008</td>
<td>Inpatient</td>
<td>Certified</td>
<td>Please Select</td>
</tr>
</tbody>
</table>

Showing 1 to 2 of 2 entries

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6136
Fax: 866-227-9481
5.8 Pharmacy Staff Associate to Pharmacy

To identify your certified pharmacy, please complete the fields below and select Search. All fields are required unless otherwise indicated.

Pharmacy Information (at least one identifier is required):

<table>
<thead>
<tr>
<th>Pharmacy Zip Code</th>
<th>DEA Number</th>
<th>NPI Number</th>
<th>NCPDP Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the search results have returned your record, please highlight the row and select the Submit button. If you do not see your record, please try your search again or contact the SILIQ REMS Program for assistance.

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Pharmacy Address</th>
<th>Pharmacy Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>5228 N Roxie Drive DURHAM North Carolina 27704</td>
<td>919-333-7325</td>
</tr>
</tbody>
</table>

Showing 1 to 2 of 2 entries
5.9 Pharmacy Staff Disassociate from Pharmacy

Disassociate from Pharmacy

Please select the Confirm button to remove this pharmacy from the list of pharmacies on your dashboard.

Cancel  Confirm
5.10 Pharmacy Staff Edit Profile

My Profile

My Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>John</td>
</tr>
<tr>
<td>Last Name</td>
<td>Doe</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:jDoe@gmail.com">jDoe@gmail.com</a></td>
</tr>
<tr>
<td>Telephone Number</td>
<td>555-555-6555</td>
</tr>
<tr>
<td>Alternate Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td>555-555-3434</td>
</tr>
<tr>
<td>Preferred Method of Communication</td>
<td>Fax</td>
</tr>
</tbody>
</table>

My Enrollment

Enrollment ID: <Enrollment ID>

[Buttons: Cancel, Save]
5.11 Predispense Authorization (PDA) Intake

Predispense Authorization

To determine if the safe use conditions have been met to receive SILIQ, please complete the Predispense Authorization information below and submit.

The results of the Predispense Authorization will be displayed after the information is submitted. All fields listed below are required unless otherwise indicated.

Patient Information

<table>
<thead>
<tr>
<th>First Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>MM/DD/YYYY</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

Predispense Authorization Request

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDC Number</td>
<td>– Please Select –</td>
</tr>
<tr>
<td>Days Supply</td>
<td></td>
</tr>
<tr>
<td>Number of Packs</td>
<td></td>
</tr>
</tbody>
</table>

Prescriber Identifiers (at least one identifier is required)

<table>
<thead>
<tr>
<th>Prescriber NPI Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber DEA Number</td>
<td></td>
</tr>
</tbody>
</table>

[Submit] [Cancel]
5.12 Predispense Authorization (PDA) Confirmation

Predispense Authorization Result

☑ This Predispense Authorization Request has been Approved

Authorization Number: AUTH-1234-5678-9100

- Patient Enrollment ID: <XXXXXXXXXX>
- Prescriber Certification ID: <XXXXXXXXXX>
- Pharmacy Certification ID: <XXXXXXXXXX>

Email: SILIQ@siliqrems.com
Phone: 855-511-6130
Fax: 866-227-9451
5.13 Predispose Authorization (PDA) Rejection

Do NOT dispense Siliq.
<Reject Reason>
Please call the Siliq REMS Program at 855-511-6135 for more information.
6. Account

6.1 Change Password

Change Password

To change your password, please complete fields below.

Current Password

New Password

Confirm New Password

[Submit]
6.2 Change Username

To change your username, please provide your new username below. The information you provide for your username must be unique within the SILIQ REMS Program Website.

Username

☐ Use Email Address as Username  ☒ Suggest Username

Cancel  Save
6.3 Edit Prescriber Profile

My Profile

My Information

First Name: John
Last Name: Doe
Email Address: johndoe@email.com
Degree: MD
Specialty: General
Name of Institution/Healthcare Facility: Good Health Clinic
Street Address: 1 Main Street
City: New York
State: New York
Zip Code: 10001
Office Phone Number: 555-555-5555
Mobile Phone Number (Optional): 555-555-5111
Office Fax Number: 555-555-0000
Preferred Method of Communication: Email

Prescriber Identifiers

DEA Number (Optional): AB23423412
NPI Number: 2342342323

My Certification

Certification ID: HCP123546789

Cancel  Save