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-Prescriber Agreement Form
- SILIQ REMS Program Patient-Prescriber Agreement Form (Spanish)
- SILIQ Prescribing Information

Materials for Pharmacies
- SILIQ REMS Program Pharmacy Enrollment Form

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)

Email: SILIQ@SILIQREMS.com
Phone: 855-511-5135
Fax: 866-227-9451
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-Physician 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.

Start Prescriber Certification
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.

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)

Contact Us | Privacy Policy | Terms and Conditions | Site Map
1.5 Pharmacy Staff Landing Page

Pharmacy Staff

Steps for Pharmacy Staff Enrollment

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.

Pharmacy staff must complete the following steps to enroll in the SILIQ REMS Program:

1. Create an online account
2. Associate to a Pharmacy
3. Certify by completing and submitting the pharmacy staff member information and attestation

Start Pharmacy Staff Enrollment

Email: SILIQ@siliqrems.com
Phone: 666-511-5135
Fax: 866-227-9451
1.6 Site Map

Prescribers

Pharmacy

Patient

General

Account

Prescriber

Pharmacy Certification

Pharmacy Certification

Patient Information

Forgot Password

Forgot Username

Need an Account

Contact Us

Privacy

Terms of Use

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6136
Fax: 866-227-9451
1.7 Prescriber Search Page – with results

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

First Name: [Field]  Last Name: [Field]  Certification ID (Optional): [Field]
Phone: [Field]  Fax: [Field]  Email (Optional): [Field]

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.

First Name: John  Last Name: Doe  Phone: 555-555-5555

Showing 1 to 1 of 1 entries

New User  Submit
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

NPI

DEA (Optional)

First Name

Last Name

Certification ID (Optional)

Phone

Fax

Email (Optional)

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.

New User
1.9 Pharmacy Search Page – with results

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.

User 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.

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

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)

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.

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

[ ] Use Email Address as Username
[ ] Suggest Username

Password
Confirm Password

[ ] I'm not a robot

Cancel Submit
1.12 Certified Pharmacies

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

<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>FACs6670655</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

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6135
Fax: 865-227-9451
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

Contact Us

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

Phone Number
855-511-8135

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

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@SILIQRIMS.com
Phone: 866-511-6135
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

---

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6135
Fax: 855-227-9451

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3.2 Authorized Representative Confirmation Page

SILIQ
(brodalumab) injection
210 mg/1.5 mL

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@SILIQRMS.com
Phone: 855-511-6135
Fax: 866-227-9451
### 3.3 Pharmacy Information Page

**SILIQ**
(brodalumab) injection
210 mg/1.5 mL

#### 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.

<table>
<thead>
<tr>
<th>Pharmacy Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Name</td>
</tr>
<tr>
<td>Pharmacy Type</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEA Number</td>
</tr>
<tr>
<td>NPI Number</td>
</tr>
<tr>
<td>NCQIP Number</td>
</tr>
</tbody>
</table>

[Cancel] [Next]
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 on the print 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 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 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

Email: SILIQ@SILIQREMS.com
Phone: 866-518-5135
Fax: 866-227-3451

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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.

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### 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**

- **Cancel**
- **Next**

---

Email: SILIQ@SILIQREMS.com  
Phone: 855-511-6130  
Fax: 866-227-9401
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 attested 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.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Signature Date</th>
</tr>
</thead>
</table>

[Submit] [Back]
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
- Phone Number
- Race
- Address
- City
- State
- 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

Signature Date

Please enter your name as your electronic signature

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: 888-511-6135
Fax: 866-227-9451
5. Dashboard

5.1 Prescriber Dashboard

![Prescriber Dashboard Screen Capture]

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6135
Fax: 866-227-9451
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: 05/02/1982
Phone: 555-555-0011
State: New York
Zip Code: 10001

Patient Enrollment Information

Enrollment ID: PAT123456789

[Buttons: Cancel, Save]
5.4 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 Prestamp 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 85009</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 85009</td>
<td>Outpatient</td>
<td>FAC1000000001</td>
<td>Certified</td>
<td>Please Select Go</td>
</tr>
</tbody>
</table>

Showing 1 to 2 of 2 entries
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: 665-555-5555
Alternate Telephone Number (Optional): 555-555-4444
Office Fax: 555-555-0000
Preferred Method of Communication: Email

Save
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: 2342342323
- NCPDP Number: 123456789

Certification ID: FAC123456789

[Buttons: Cancel, Save]
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 &lt; Go</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 &lt; Go</td>
</tr>
</tbody>
</table>

Showing 1 to 2 of 2 entries

Email: SILIQ@SILIQREMS.com  
Phone: 855-511-8136  
Fax: 666-227-9401
5.8 Pharmacy Staff Associate to Pharmacy

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):

- **Pharmacy Zip Code:**
- **DEA Number:**
- **NPI Number:**
- **NCPDP Number:**

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.

**Pharmacy Name:** ABC Pharmacy
**Pharmacy Address:** 5228 N Roxie Drive, DURHAM, North Carolina 27704
**Pharmacy Phone:** 919-333-7325

Showing 1 to 2 of 2 entries

- [Search]
- [Cancel]
- [Submit]
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>555-555-5555</td>
</tr>
<tr>
<td>Alternate Telephone Number (Optional)</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

First Name
Last Name
Date of Birth
Zip Code

Predispense Authorization Request

Date of Service
NDC Number
– Please Select –
Days Supply
Number of Packs

Prescriber Identifiers (at least one identifier is required)

Prescriber NPI Number
Prescriber DEA Number

Cancel
Submit
5.12 Predispense Authorization (PDA) Confirmation

![SILIQ Website Screen Captures](image)

Prescribing Information | Medication Guide
Username | My Dashboard

### Predispense Authorization Result

![This Predispense Authorization Request has been Approved](image)

Authorization Number: **AUTH-1234-5678-9100**

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

Contact Us | Privacy Policy | Terms and Conditions | Site Map
5.13 Predispense Authorization (PDA) Rejection

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

Email: SILIQ@SILIQREMS.com
Phone: 855-511-6135
Fax: 866-227-9451
6. Account

6.1 Change Password
6.2 Change Username

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

Email: SILIQ@SILIQLMS.com
Phone: 855-511-6135
Fax: 866-227-9451
6.3 Edit Prescriber 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:john.doe@email.com">john.doe@email.com</a></td>
</tr>
<tr>
<td>Degree</td>
<td>MD</td>
</tr>
<tr>
<td>Specialty</td>
<td>General</td>
</tr>
<tr>
<td>Name of Institution/Healthcare Facility</td>
<td>Good Health Clinic</td>
</tr>
<tr>
<td>Street Address</td>
<td>1 Main Street</td>
</tr>
<tr>
<td>City</td>
<td>New York</td>
</tr>
<tr>
<td>State</td>
<td>New York</td>
</tr>
<tr>
<td>Zip Code</td>
<td>10001</td>
</tr>
<tr>
<td>Office Phone Number</td>
<td>555-555-5555</td>
</tr>
<tr>
<td>Mobile Phone Number (Optional)</td>
<td>555-555-5511</td>
</tr>
<tr>
<td>Office Fax Number</td>
<td>555-555-0000</td>
</tr>
<tr>
<td>Preferred Method of Communication</td>
<td>Email</td>
</tr>
</tbody>
</table>

Prescriber Identifiers

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEA Number</td>
<td>AB23423412</td>
</tr>
<tr>
<td>NPI Number</td>
<td>23423423423</td>
</tr>
</tbody>
</table>

My Certification

Certification ID: HCP123546789 🪴

[Buttons: Cancel, Save]