

**Instructions for Prescribers**

1. Sign this form along with your patient.
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 REMS online at [www.SILIQREMS.com](http://www.SILIQREMS.com) or by fax at 866-227-9451.

**Patient Acknowledgement (\*Indicates required field)**

By signing this form, I acknowledge that:

- I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ, and may occur at any time during treatment.
- I will call my doctor or the **National Suicide Prevention Lifeline at 1-800-273-8255** if:
  - o I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning.
  - o 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 *Patient Wallet Card* to carry with me at all times.
- I understand that the SILIQ REMS may contact me or my prescriber to support administration of the SILIQ REMS.

**(\*Indicates required field)**

First Name*:		Middle Initial:	Last Name*:	
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Neutral <input type="checkbox"/> Prefer Not to Say		Date of Birth (Month/Day/Year)*:		
Address*:		City*:	State*:	Zip Code*:
Race*: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other _____			Phone Number*:	
Patient Signature*:		Date*:	Email:	

**Prescriber Acknowledgement (\*Indicates required field)**

I acknowledge that prior to prescribing SILIQ:

- I have counseled my patient about the importance of seeking medical attention 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.

First Name*:		Middle Initial:	Last Name*:	
Phone Number*:		NPI*:		
Prescriber Signature*:			Date*:	

<b>SILIQ</b> (brodalumab) injection 210 mg/1.5 mL	<b>SILIQ Patient Information</b>
<ul style="list-style-type: none"><li>• I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ, and may occur at any time during treatment.</li><li>• I will call my doctor or the <b>National Suicide Prevention Lifeline at 1-800-273-8255</b> if:<ul style="list-style-type: none"><li>o I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning.</li><li>o 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.</li></ul></li><li>• I will <b>call 911</b> if I feel an <b>immediate threat of death or self-injury</b>.</li></ul>	
<b>Please visit <a href="http://www.SILIQREMS.com">www.SILIQREMS.com</a> or call 855-511-6135 for more information about the SILIQ REMS.</b>	