

Instructions

1. Review the SILIQ Prescribing Information.
 2. Complete and fax this form to the SILIQ REMS at 866-227-9451, submit online at www.SILIQREMS.com, or email it to SILIQ@SILIQREMS.com.
 3. Send your patient's prescription to a pharmacy that is enrolled in the SILIQ REMS using the Pharmacy Certification Look Up function on the SILIQ REMS website.
- You will receive enrollment confirmation via your preferred method of communication (email or fax) within one business day.

SILIQ Prescriber Information (*Indicates required field)

First Name*:	Middle Initial:	Last Name*:
National Provider Identification (NPI) Number*:	Degree*: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> Other	
Name of Institution or Healthcare Facility*:	Specialty*:	
Street Address*:		
City*:	State*:	Zip Code*:
Office Phone Number*:	Office Fax Number*:	Mobile Phone Number:
Email Address:	Preferred Method of Communication*: <input type="checkbox"/> Email <input type="checkbox"/> Fax	

Prescriber Agreement

By completing this form, I attest that:

1. I have read and understand the SILIQ *Prescribing Information*.
2. I will comply with the REMS requirements in order to prescribe SILIQ.
3. I understand that by signing this form (*one-time only*), I will be enrolled in the SILIQ REMS and may prescribe SILIQ.
4. Prior to treatment initiation, 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 my 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 seek medical attention for suicidal thoughts and behavior, new onset or worsening symptoms of depression, anxiety, or other mood changes.
5. I understand that patients with a history of suicidality or depression have an increased incidence of suicidal ideation and behavior as compared to users without such a history.
6. I will submit a completed *SILIQ REMS Patient Enrollment Form* for each patient before I prescribe SILIQ for the first time. I will provide a completed copy of the form to each patient.
7. I will provide each patient with a *SILIQ REMS Patient Wallet Card* and instruct each patient to carry this card with them at all times.
8. I understand that patients with suicidal thoughts and behavior, new onset or worsening symptoms of depression, anxiety or other mood changes should be referred to a mental health professional, as appropriate.
9. I will inform the SILIQ REMS if an enrolled patient has discontinued therapy or is no longer under my care.
10. I understand Bausch Health US, LLC and its agents may contact me via phone, mail, fax, email, or in person to support administration of the SILIQ REMS.

Prescriber Signature*:	Date*:
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Please visit www.SILIQREMS.com or call 855-511-6135 for more information about the SILIQ REMS.