

Risk Evaluation and Mitigation Strategy (REMS) Document

SILIQ® (brodalumab) REMS Program

I. Administrative Information

Application Number: BLA 761032
Application Holder: Bausch Health US, LLC
Initial REMS Approval: 02/2017
Most Recent REMS Update: 01/2021

II. REMS Goal

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:

1. 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.
2. 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.

III. REMS Requirements

Bausch Health US, LLC must ensure that healthcare providers, patients, pharmacies, and wholesalers-distributors comply with the following requirements:

1. Healthcare providers who prescribe SILIQ must:

To become certified to prescribe	<ol style="list-style-type: none">1. Review the drug's Prescribing Information.2. Enroll in the REMS by completing the Prescriber Enrollment Form and submitting it to the REMS Program.
Before treatment initiation (first dose)	<ol style="list-style-type: none">3. Counsel the patient on the risk of suicidal ideation and behavior including that completed suicides have occurred with patients treated with SILIQ, symptoms may occur at any time during treatment, the need to seek medical attention for suicidal thoughts and behavior, new onset or worsening symptoms of depression, anxiety, or other mood changes, and the importance of keeping the Patient Wallet Card with them at all times.

1. Healthcare providers who prescribe SILIQ must:

- | | |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ol style="list-style-type: none">4. Provide the patient with the Patient Wallet Card.5. Enroll the patient by completing and submitting the Patient Enrollment Form to the REMS Program. Provide a completed copy of the form to the patient. |
| At all times | <ol style="list-style-type: none">6. Report treatment discontinuation or transfer of care to the REMS Program. |
-

2. Patients who are prescribed SILIQ:

- | | |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Before treatment initiation | <ol style="list-style-type: none">1. Receive counseling from the prescriber on the risk of suicidal ideation and behavior including that completed suicides have occurred with patients treated with SILIQ, symptoms may occur at any time during treatment, the need to seek medical attention for suicidal thoughts and behavior, new onset or worsening symptoms of depression, anxiety, or other mood changes, and the importance of keeping the Patient Wallet Card with you at all times.2. Enroll in the REMS Program by completing the Patient Enrollment Form with the prescriber. Enrollment information will be provided to the REMS Program.3. Receive the Patient Wallet Card. |
| At all times | <ol style="list-style-type: none">4. Have the Patient Wallet Card with you.5. Inform the prescriber if you have suicidal thoughts or behavior, or any new or worsening symptoms of depression, anxiety, or other mood changes. |
-

3. Pharmacies that dispense SILIQ must:

- | | |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| To become certified to dispense | <ol style="list-style-type: none">1. Designate an authorized representative to carry out the certification process and oversee implementation and compliance with the REMS Program on behalf of the pharmacy.2. Have the authorized representative enroll in the REMS by completing the Pharmacy Enrollment Form and submitting it to the REMS Program. |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
-

3. Pharmacies that dispense SILIQ must:

	3. Train all relevant staff involved in dispensing SILIQ on the REMS Program requirements as described on the Pharmacy Enrollment Form .
Before dispensing	4. Obtain authorization to dispense each prescription by contacting the REMS Program to verify the prescriber is certified and the patient is enrolled.
To maintain certification to dispense	5. Have a new authorized representative enroll in the REMS program by completing and submitting the Pharmacy Enrollment Form to the REMS.
At all times	6. Maintain records that all processes and procedures are in place and being followed. 7. Comply with audits by Bausch Health US, LLC or third party acting on behalf of Bausch Health US, LLC to ensure that all processes and procedures are in place and are being followed.

4. Wholesalers-distributors that distribute SILIQ must:

To be able to distribute	1. Establish processes and procedures to ensure that the drug is distributed only to certified pharmacies. 2. Train all relevant staff involved in distribution on the REMS requirements.
At all times	3. Distribute only to certified pharmacies. 4. Maintain and submit records of all drug distribution to the REMS Program. 5. Maintain records that all processes and procedures are in place and being followed. 6. Comply with audits by Bausch Health US, LLC or a third party acting on behalf of Bausch Health US, LLC to ensure that all processes and procedures are in place and are being followed.

To support REMS Program operations, Bausch Health US, LLC must:

1. Establish and maintain a REMS Program website (www.SILIQREMS.com). The REMS Program website must include the capability to complete prescriber and pharmacy certification online, to enroll patients online, to confirm patient authorization status, and the option to print the Prescribing Information, Medication Guide, and SILIQ REMS

materials. All product websites for consumers and healthcare providers must include prominent REMS-specific links to the REMS Program website. The REMS Program website must not link back to the promotional product website(s).

2. Make the REMS Program website fully operational and all REMS materials available through the call center and www.SILIQREMS.com within 90 calendar days of REMS modification (01/22/2021).
3. Establish and maintain a REMS Program Call Center for REMS participants at 855-511-6135.
4. Establish and maintain a validated, secure database of all REMS participants who are enrolled and/or certified in the SILIQ REMS Program.
5. Ensure prescribers are able to become certified online, by email, and by fax.
6. Ensure that prescribers are able to enroll patients in the REMS online, by email, and by fax.
7. Ensure that pharmacies are able to become certified in the REMS online, by email, and by fax.
8. Ensure pharmacies are able to obtain authorization to dispense online and by phone.
9. Provide the [Prescriber Enrollment Form](#), [Patient Enrollment Form](#), [Patient Wallet Card](#), and Prescribing Information to healthcare providers who (1) attempt to prescribe or dispense SILIQ and are not yet certified, or (2) inquire about how to become certified.
10. Provide the [Pharmacy Enrollment Form](#) to pharmacies who (1) attempt to order SILIQ and are not yet certified, or (2) inquire about how to become certified.
11. Notify pharmacies and prescribers within one business day after they become certified in the REMS Program.
12. Provide certified prescribers access to the database of certified pharmacies and enrolled patients.
13. Provide certified pharmacies access to the database of certified prescribers and enrolled patients.

To ensure REMS participants' compliance with the REMS Program, Bausch Health US, LLC must:

14. Verify annually that the authorized representative's name and contact information correspond to those of the current designated authorized representative for the pharmacy. If different, the pharmacy must be required to recertify with a new authorized representative.
15. Maintain adequate records to demonstrate that REMS requirements have been met, including, but not limited to records of: SILIQ distribution and dispensing; certification of prescribers, pharmacies; enrolled patients; and audits of REMS participants. These records must be readily available for FDA inspections.
16. Establish a plan for addressing noncompliance with REMS Program requirements.
17. Monitor prescribers, pharmacies, and wholesalers-distributors on an ongoing basis to ensure the requirements of the REMS are being met. Take corrective action if non-compliance is identified, include de-certification.
18. Audit 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. Certified pharmacies must be identified in Bausch Health's ongoing annual audit plan.

19. Audit wholesalers-distributors that have distributed SILIQ no later than 90 calendar days after they become authorized to distribute the drug and annually thereafter to ensure that all REMS processes and procedures are in place, functioning, and support the REMS requirements.
20. Take reasonable steps to improve implementation of and compliance with the requirements of the SILIQ REMS Program based on monitoring and evaluation of the SILIQ REMS Program.

IV. REMS Assessment Timetable

Bausch Health US, LLC must submit REMS assessments at 6 months, 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 US, LLC must submit each assessment so that it will be received by the FDA on or before the due date.

V. REMS Materials

The following materials are part of the SILIQ REMS:

Enrollment Forms

Prescriber:

1. [Prescriber Enrollment Form](#)

Patient:

2. [Patient Enrollment Form](#)

Pharmacy:

3. [Pharmacy Enrollment Form](#)

Training and Educational Materials

Patient:

4. [Patient Wallet Card](#)

Other Materials

5. [REMS Program Website](#)

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.

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 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:
 - 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 *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*:	

<p>SILIQ (brodalumab) injection 210 mg/1.5 mL</p>	<p>SILIQ Patient Information</p>
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> <input type="checkbox"/> I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes beginning. <input type="checkbox"/> 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. 	
<p>Please visit www.SILIQREMS.com or call 855-511-6135 for more information about the SILIQ REMS.</p>	

Instructions

1. Designate an authorized representative to ensure compliance with the SILIQ REMS.
2. Review, 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.

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

Authorized Representative Responsibilities

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

1. I understand that by signing this form, and upon confirmation from the SILIQ REMS, this pharmacy will be enrolled in the SILIQ REMS, and will be able to order and dispense SILIQ.
2. This pharmacy will re-enroll in the SILIQ REMS if the name and contact information for the authorized representative changes.
3. This pharmacy will ensure that all relevant staff involved in dispensing SILIQ are trained on the SILIQ REMS requirements.
4. This pharmacy will maintain and make available appropriate records 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 will result in decertification of my pharmacy and termination of authorization to dispense SILIQ.
6. I will ensure that before dispensing, all pharmacy staff obtain authorization to dispense each prescription by contacting the SILIQ REMS to verify the prescriber is certified and the patient is enrolled.
7. This pharmacy will comply with audits by Bausch Health US, LLC or a third-party acting on behalf of Bausch Health US, LLC to ensure that processes and procedures are in place and are being followed.

Pharmacy Information (*Indicates required field)

Pharmacy Name*:		Pharmacy Type*: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		
Address*:		City*:	State*:	Zip Code*:
Pharmacy Identifier* (at least one required):	NPI:	NCPDP:		

Authorized Pharmacy Representative Information (*Indicates required field)

First Name*:	Middle Initial:	Last Name*:		
Telephone Number*:	Alternate Telephone Number:	Office Fax*:		
Email*:		Preferred Method of Communication*: <input type="checkbox"/> Email <input type="checkbox"/> Fax		
Authorized Pharmacy Representative Signature*:				Date*:

Please visit www.SILIQREMS.com or call 855-511-6135 for more information about the SILIQ REMS.

SILIQ

(brodalumab) injection
210 mg/1.5 mL

SILIQ[®] REMS
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 dying².

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.

For more information, visit www.SILIQREMS.com or call 855-511-6135.

¹ American Association of Suicidology. Know the Warning Signs of Suicide. <http://www.suicidology.org/resources/warning-signs>.

² American Foundation for Suicide Prevention. Suicide Warning Signs: <https://afsp.org/risk-factors-and-warning-signs>.
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SILIQ

(brodalumab) injection
210 mg/1.5 mL

Username

Password

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Prescribers

Pharmacies

Patients

What is the SILIQ REMS (Risk Evaluation and Mitigation Strategy)?

The SILIQ REMS is a safety program to manage the observed risk of suicidal ideation and behavior, including completed suicides, which occurred in subjects treated with SILIQ.

A REMS is required by the U.S. Food and Drug Administration (FDA) to ensure that the benefits of SILIQ outweigh its risks.

SILIQ REMS Overview

- Educate prescribers about the risk of suicidal ideation and behavior observed with SILIQ therapy and the need to counsel patients about this risk.
- Educate patients 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.


[Start Prescriber Certification](#)
[Start Pharmacy Certification](#)

Materials for Prescribers

-  [SILIQ REMS Prescriber Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form \(Spanish\)](#)
-  [SILIQ Prescribing Information](#)

Materials for Pharmacies

-  [SILIQ REMS Pharmacy Enrollment Form](#)

Materials for Patients

-  [SILIQ REMS Patient Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form \(Spanish\)](#)
-  [SILIQ REMS Patient Wallet Card](#)
-  [SILIQ REMS Patient Wallet Card \(Spanish\)](#)



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribing Information | Medication Guide

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Prescriber Certification

Prescribers must be certified in the SILIQ REMS to prescribe SILIQ

To complete prescriber certification:

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

COMPLETE a *SILIQ REMS 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 Patient Enrollment Form* for each new patient before prescribing SILIQ and submit the completed form to the SILIQ REMS

Start Prescriber Certification

Materials for Prescribers

-  [SILIQ REMS Prescriber Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form \(Spanish\)](#)
-  [SILIQ Prescribing Information](#)

Materials for Patients

-  [SILIQ REMS Patient Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form \(Spanish\)](#)
-  [SILIQ REMS Patient Wallet Card](#)
-  [SILIQ REMS Patient Wallet Card \(Spanish\)](#)

Email: SILIQ@SILIQREMS.com

Phone: 855-511-6135

Fax: 866-227-9451

Reference ID: 4734968

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Pharmacy Certification

All pharmacies must certify in the SILIQ REMS 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
- Establishes and implements processes and procedures to ensure compliance with the safe use conditions of the SILIQ REMS

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

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

CERTIFY by completing and submitting the *SILIQ REMS Pharmacy Enrollment Form*

Start Pharmacy Certification

Materials for Pharmacies



SILIQ REMS Pharmacy Enrollment Form



SILIQ Prescribing Information



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribing Information | Medication Guide

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Patient's Role in the SILIQ REMS:

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 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 Patient Enrollment Form*.

Materials for Patients

-  [SILIQ REMS Patient Enrollment Form](#)
-  [SILIQ REMS Patient Enrollment Form \(Spanish\)](#)
-  [SILIQ REMS Patient Wallet Card](#)
-  [SILIQ REMS Patient Wallet Card \(Spanish\)](#)

Email: SILIQ@SILIQREMS.com

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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 to have access to the SILIQ REMS Website. Pharmacy staff can associate to one or more pharmacy locations.

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

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

Pharmacy Certification

Certified Pharmacies

Pharmacy Staff Enrollment



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Account

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[Forgot Username](#)

[Need an Account](#)



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Prescribers Pharmacies Patients

User Search

If you began or completed certification through a fax process, you may already be certified in the SILIQ REMS. 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.

NPI		
<input type="text"/>		
First Name	MI (Optional)	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone	Fax	
<input type="text"/>	<input type="text"/>	
Certification ID (Optional)	Email (Optional)	
<input type="text"/>	<input type="text"/>	
		<input type="button" value="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.

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

Showing 1 to 1 of 1 entries 1 >> 10 ▾

New User

Submit



Sign in

[Forgot Username?](#) [Forgot Password?](#) [Need an Account?](#)

Prescribers

Pharmacies

Patients

User Search

If you began or completed certification through a fax process, you may already be certified in the SILIQ REMS. 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.

NPI

First Name

MI (Optional)

Last Name

Phone

Fax

Certification ID (Optional)

Email (Optional)

Search

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

First Name ▲

Last Name ▼

Phone ▼

No matching records found.

Showing 0 to 0 of 0 entries

0 >>

10 ▼

New User



Sign in

[Forgot Username?](#) [Forgot Password?](#) [Need an Account?](#)

Prescribers

Pharmacies

Patients

User Search

If you began or completed certification through a fax process, you may already be certified in the SILIQ REMS. 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

and

NPI Number

or

NCPDP Number

First Name

MI (Optional)

Last Name

Phone

Fax

Certification ID (Optional)

Email (Optional)

Search

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

First Name ▲

Last Name ▼

Pharmacy Name ▼

Pharmacy Address ▼

Pharmacy Phone ▼

Pharmacy Type ▼

No matching records found

Showing 0 to 0 of 0 entries

0 >>

10 ▼

New User



Sign in

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Prescribers

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Create an Account

To create your web account for the SILIQ REMS, please complete the fields below. The Username you specify must be unique within the SILIQ REMS 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

MI (Optional)

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



Username

Password

Sign in

[Forgot Username?](#) [Forgot Password?](#) [Need an Account?](#)

Prescribers

Pharmacies

Patients

SILIQ Certified Pharmacy Network

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

Pharmacy Certification

Certified Pharmacies

Pharmacy Staff Enrollment

Prescriptions for restricted distribution programs for SILIQ.

Pharmacy Name ▲	Certification ID ▲	Pharmacy Address ▲	Pharmacy Phone ▲	Pharmacy Fax ▲
Uptown Drugs	FAC399878655	5228 N Roxie Drive DURHAM North Carolina 27704	919-333-7325	555-555-5555

Showing 1 to 2 of 2 entries

1 » 10 ▼ 

Email: SILIQ@SILIQREMS.com

Phone: 855-511-6135

Fax: 866-227-9451

Reference ID: 4734968

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SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Sign in

[Forgot Username?](#) [Forgot Password?](#) [Need an Account?](#)

Prescribers

Pharmacies

Patients

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.

First Name

MI (Optional)

Last Name

Email Address

Submit

Email: SILIQ@SILIQREMS.com

Phone: 855-511-6135

Fax: 866-227-9451

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SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Sign in

[Forgot Username?](#) [Forgot Password?](#) [Need an Account?](#)

Prescribers

Pharmacies

Patients

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.

Username

Email Address

Submit

Email: SILIQ@SILIQREMS.com

Phone: 855-511-6135

Fax: 866-227-9451

Reference ID: 4734968

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SILIQ.

(brodalumab) injection
210 mg/1.5 mL

[Prescribing Information](#) | [Medication Guide](#)

[Sign in](#)

[Forgot Username?](#) [Forgot Password?](#) [Need an Account?](#)

[Prescribers](#)

[Pharmacies](#)

[Patients](#)

Contact Us

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

Phone Number

855-511-6135

Fax Number

866-227-9451

Email Address

SILIQ@SILIQREMS.com

Mailing Address

SILIQ REMS

PO Box 52170

Phoenix, AZ 85072

Program Manufacturer

Bausch Health US, LLC

Email: email@email.com

Phone: 855-511-6135

Fax: 866-227-9451

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Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

Prescriber Intake

To certify as a prescriber in the SILIQ REMS, please complete the required fields below and press **Next**. Once certified, you will receive a certification confirmation via your preferred method of communication. All fields listed below are required unless otherwise indicated.

Prescriber Information

First Name MI (Optional)

Last Name

Email Address

Degree -- Please Select -- 

Specialty

Name of Institution/Healthcare Facility

Street Address

City

State -- Please Select --  Zip Code

Office Phone Number

Mobile Phone Number (Optional)

Office Fax Number

Preferred Method of Communication -- Please Select -- 

Prescriber Identifiers

NPI Number

Cancel

Next



Prescriber Attestation

To complete the prescriber certification for **John Smith** into the SILIQ REMS online, please review the attestation section below and 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 at 866-227-9451. 

As a prescriber, 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.

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

Signature

Signature Date

Back

Submit

SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

Prescriber Certification Confirmation



You are now certified in the SILIQ REMS.

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

Certification ID: **HCP123456879** 



Prescribers

Pharmacies

Patients

1 INTAKE

2 CONFIRMATION

Authorized Representative Intake

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

Authorized Pharmacy Representative Information

First Name

MI (Optional)

Last Name

Email Address

Confirm Email Address

Telephone Number

Alternate Telephone Number (Optional)

Office Fax

Preferred Method of Communication

-- Please Select --



Cancel

Next



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribers

Pharmacies

Patients

1 INTAKE

2 CONFIRMATION

Authorized Representative Confirmation



You are now an authorized representative in the SILIQ REMS.

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.



Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

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	<input type="text"/>
Pharmacy Type	<input type="text" value="-- Please Select --"/>
Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value="-- Please Select --"/>
Zip Code	<input type="text"/>

Pharmacy Identifiers (at least one identifier is required):

NPI Number	<input type="text"/>
NCPDP Number	<input type="text"/>

Cancel

Next



Pharmacy Attestation

To complete the Pharmacy Certification for **ABC Pharmacy** into the SILIQ REMS, 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 at 866-227-9451. 

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

1. I understand that by signing this form, and upon confirmation from the SILIQ REMS, this pharmacy will be enrolled in the SILIQ REMS, and will be able to order and dispense SILIQ.
2. This pharmacy will re-enroll in the SILIQ REMS if the name and contact information for the authorized representative changes.
3. This pharmacy will ensure that all relevant staff involved in dispensing SILIQ are trained on the SILIQ REMS requirements.
4. This pharmacy will maintain and make available appropriate records 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 will result in decertification of my pharmacy and termination of authorization to dispense SILIQ.
6. I will ensure that before dispensing, all pharmacy staff obtain authorization to dispense each prescription by contacting the SILIQ REMS to verify the prescriber is certified and the patient is enrolled.
7. This pharmacy will comply with audits by Bausch Health US, LLC, or a third-party acting on behalf of Bausch Health US, LLC to ensure that all processes and procedures are in place and are being followed.

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

Signature

Signature Date

Back

Submit



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

Pharmacy Certification Confirmation



Your pharmacy is now certified in the SILIQ REMS

Below is your SILIQ REMS 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.



Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

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 communication. All fields are required unless otherwise indicated.

Pharmacy Staff Information

First Name MI (Optional)

Last Name

Email Address

Confirm Email Address

Telephone Number

Alternate Telephone Number (Optional)

Fax

Preferred Method of Communication

Cancel

Next



Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

Pharmacy Staff Attestation

To complete pharmacy staff enrollment in the SILIQ REMS, 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.
2. I understand I can access the SILIQ REMS Website to:
 - Verify the prescriber is certified and the patient is enrolled and authorized to receive SILIQ prior to dispensing.
 - 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 requirements.

Signature

Signature Date

Back

Submit



Prescribers

Pharmacies

Patients

1 INTAKE

2 ATTESTATION

3 CONFIRMATION

Pharmacy Staff Confirmation



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

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

Enrollment ID: **<Enrollment #>**

Print

To add additional pharmacies or manage your pharmacies, please use the **My Dashboard** button at the top of the page.



Patient Acknowledgement

To enroll your patient into the SILIQ REMS, 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	<input type="text"/>	MI (Optional)	<input type="text"/>
Last Name	<input type="text"/>		
Email (Optional)	<input type="text"/>		
Gender	<input type="text" value="-- Please Select --"/>	Date of Birth	<input type="text" value="MM/DD/YYYY"/>
Phone Number	<input type="text"/>		
Race	<input type="text" value="-- Please Select --"/>		
Address	<input type="text"/>		
City	<input type="text"/>		
State	<input type="text" value="-- Please Select --"/>	Zip Code	<input type="text"/>

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-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 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 the administration of the SILIQ REMS.

Patient Signature

Signature Date

Please enter your name as your electronic signature

Cancel

Next



Patient Acknowledgement

To enroll your patient into the SILIQ REMS, 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	<input type="text"/>	MI (Optional)	<input type="text"/>
Last Name	<input type="text"/>		
Email (Optional)	<input type="text"/>		
Gender	<input type="text" value="-- Please Select --"/>	This field is required.	
Phone Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Race	<input type="text" value="Male"/> <input type="text" value="Female"/> <input type="text" value="Neutral"/> <input type="text" value="Prefer Not to Say"/>	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>		
City	<input type="text"/>		
State	<input type="text" value="-- Please Select --"/>	Zip Code	<input type="text"/>

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-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 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 the administration of the SILIQ REMS.

Patient Signature

Please enter your name as your electronic signature

Signature Date

Cancel

Next



Prescribers

Pharmacies

Patients

1 PATIENT INTAKE

2 ACKNOWLEDGEMENT

3 CONFIRMATION

Prescriber Acknowledgement

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.

Prescriber Signature

Signature Date

Please enter your name as your electronic signature

Back

Submit



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribers

Pharmacies

Patients

1 PATIENT INTAKE

2 ACKNOWLEDGEMENT

3 CONFIRMATION

Patient Enrollment Confirmation



Your patient is now enrolled in the SILIQ REMS.

Please print this information and tear off the bottom portion of the printed *SILIQ REMS Patient Enrollment Form* and provide it to your patient to take home as a reference.

Enrollment ID: **PAT123456789** 



Prescribers

Pharmacies

Patients

Prescriber Dashboard

Please search for your patient in the table below and take the appropriate action. If you need to add a new patient to your list, please use the **Add Patient** button. For taking actions, use the Actions list.

Add Patient

Search



First Name 	Middle Initial 	Last Name 	DOB 	Enrollment ID 	Enrollment Status 	Actions
Joe	B	Doe	04/16/1967	PAT123456789	Enrolled	Please Select  <input type="button" value="Go"/>
John	A	Smith	01/01/1954	PAT143443433	Enrolled	Please Select  <input type="button" value="Go"/> View Patient Profile Manage Patient Status

Showing 1 to 2 of 2 entries



Prescribers

Pharmacies

Patients

Manage Patient Status

Updating the patient status will deactivate the patient from the SILIQ REMS. 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**

MI: **A**

Last Name: **Smith**

Date of Birth: **02/02/1954**

Zip Code: **10001**

Update Patient Status:

Cancel

Submit



Prescribers

Pharmacies

Patients

Patient Profile

Edit

Patient Information

First Name	<input type="text" value="John"/>	MI (Optional)	<input type="text" value="A"/>
Last Name	<input type="text" value="Smith"/>		
Email (Optional)	<input type="text" value="Info@email.com"/>		
Gender	<input type="text" value="Male"/>	Date of Birth	<input type="text" value="05/02/1982"/>
Phone	<input type="text" value="555-555-0011"/>		
State	<input type="text" value="New York"/>	Zip Code	<input type="text" value="10001"/>

Patient Enrollment Information

Enrollment ID: **PAT123456789** 

Cancel

Save



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 Predispose Authorization*.

Add Pharmacy

Search



Pharmacy Name 	Address 	Pharmacy Type 	Certification ID 	Status 	Actions
ABC Pharmacy	1234 West Pharmacy Lane Pheonix AZ 85008	Inpatient	FAC1000000000	Certified	Please Select  <input type="button" value="Go"/>
XYZ Pharmacy	15 East Prescription Street Phoenix AZ 85008	Outpatient	FAC1000000001	Certified	Please Select  <input type="button" value="Go"/>

Showing 1 to 2 of 2 entries

1 »

10 



Prescribers

Pharmacies

Patients

My Profile

Edit

My Information

First Name

John

MI (Optional)

T

Last Name

Doe

Email Address

johndoe@email.com

Phone

555-555-5555

Alternative Phone

555-555-4444

Office Fax

555-555-0000

Preferred Method of Communication

Email

Cancel

Save



Prescribers

Pharmacies

Patients

Pharmacy Profile

Edit

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 (at least one identifier is required):

NPI Number	23423423423
NCPDP Number	123546879

Pharmacy Certification

Certification ID: **FAC123456789** 

Cancel

Save



Prescribers

Pharmacies

Patients

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.

				Associate to Pharmacy	<input type="text" value="Search"/> 
Pharmacy Name 	Address 	Pharmacy Type 	Status 	Actions	
ABC Pharmacy	1234 West Pharmacy Lane Phoenix AZ 85008	Inpatient	Certified	<input type="text" value="Please Select"/> 	<input type="button" value="Go"/>
XYZ Pharmacy	15 East Prescription Street Phoenix AZ 85008	Inpatient	Certified	<input type="text" value="Please Select"/> 	<input type="button" value="Go"/>

Showing 1 to 2 of 2 entries 1 » 



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		and	Identifiers	
<input type="text"/>			NPI Number	NCPDP Number
			<input type="text"/>	<input type="text"/>
			or	

Search

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 for assistance.

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

Showing 1 to 2 of 2 entries 1 » 10 ▾

Cancel

Submit



Prescribers

Pharmacies

Patients

Disassociate from Pharmacy

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

Cancel

Confirm

My Dashboard

The table below contains all of
button. For taking actions, use

Pharmacy Name

ABC Pharmacy

XYZ Pharmacy

1234 West Pharmacy Lane Phoenix AZ 85008

15 East Prescription Street Phoenix AZ 85008

Inpatient

Inpatient

Certified

Certified

Associate to Pharmacy

Search 

Actions

Please Select 

Go

Please Select 

Go

Showing 1 to 2 of 2 entries

1 » 10 



- Change Username
- Change Password
- Edit Profile
- Sign Out

Prescribers

Pharmacies

Patients

My Profile

Edit

My Information

First Name MI (Optional)

Last Name

Email Address

Telephone Number

Alternate Telephone Number (Optional)

Fax

Preferred Method of Communication

My Enrollment

Enrollment ID: [<Enrollment ID>](#)

Cancel

Save



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

MI (Optional)

Last Name

Date of Birth

MM/DD/YYYY

Zip Code

Predispense Authorization Request

Date of Service

MM/DD/YYYY

NDC Number

-- Please Select --



Days Supply

Number of Packs

Prescriber Identifiers

Prescriber NPI Number

Cancel

Submit



SILIQ.

(brodalumab) injection

210 mg/1.5 mL

Username 

My Dashboard

Prescribers

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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: 855-511-6135

Fax: 866-227-9451

Reference ID: 4734968



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Prescribers

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Predispense Authorization Result

 **Do NOT dispense SILIQ**

<Reject Reason>

Please call the SILIQ REMS at 855-511-6135 for more information.



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Username 

My Dashboard

My Profile

Change Username

Change Password

Sign Out

Prescribers

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Patients

Change Password

To change your password, please complete fields below.

Current Password

New Password

Confirm New Password

Cancel

Save

Email: SILIQ@SILIQREMS.com

Phone: 855-511-6135

Fax: 866-227-9451

Reference ID: 4734968



SILIQ.

(brodalumab) injection
210 mg/1.5 mL

Username 

My Dashboard

My Profile

Change Username

Change Password

Sign Out

Prescribers

Pharmacies

Patients

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 Website.

Username

Use Email Address as Username

 Suggest Username

Cancel

Save

Email: SILIQ@SILIQREMS.com

Phone: 855-511-6135

Fax: 866-227-9451

Reference ID: 4734968



- My Profile
- Change Username
- Change Password
- Sign Out

Prescribers

Pharmacies

Patients

My Profile

Edit

My Information

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

Prescriber Identifiers

NPI Number

My Certification

Certification ID: **HCP123546789** 

Cancel

Save



This is a representation of an electronic record that was signed electronically. Following this are manifestations of any and all electronic signatures for this electronic record.

/s/

TATIANA OUSSOVA
01/22/2021 01:07:18 PM