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: 06/2022

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

   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)

   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.

Reference ID: 4998927
1. Healthcare providers who prescribe SILIQ must:

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>4.</td>
<td>Provide the patient with the Patient Wallet Card.</td>
</tr>
<tr>
<td>5.</td>
<td>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.</td>
</tr>
</tbody>
</table>

At all times 6. Report treatment discontinuation or transfer of care to the REMS Program.

2. Patients who are prescribed SILIQ:

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<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Before treatment initiation 1.</td>
<td>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.</td>
</tr>
<tr>
<td>2.</td>
<td>Enroll in the REMS Program by completing the Patient Enrollment Form with the prescriber. Enrollment information will be provided to the REMS Program.</td>
</tr>
<tr>
<td>3.</td>
<td>Receive the Patient Wallet Card.</td>
</tr>
</tbody>
</table>

At all times 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:

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>To become certified to dispense 1.</td>
<td>Designate an authorized representative to carry out the certification process and oversee implementation and compliance with the REMS Program on behalf of the pharmacy.</td>
</tr>
<tr>
<td>2.</td>
<td>Have the authorized representative enroll in the REMS by completing the Pharmacy Enrollment Form and submitting it to the REMS Program.</td>
</tr>
</tbody>
</table>
### 3. Pharmacies that dispense SILIQ must:

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before dispensing</td>
<td>3. Train all relevant staff involved in dispensing SILIQ on the REMS Program requirements as described on the Pharmacy Enrollment Form.</td>
</tr>
<tr>
<td>To maintain certification to dispense</td>
<td>4. Obtain authorization to dispense each prescription by contacting the REMS Program to verify the prescriber is certified and the patient is enrolled.</td>
</tr>
<tr>
<td>At all times</td>
<td>5. Have a new authorized representative enroll in the REMS program by completing and submitting the Pharmacy Enrollment Form to the REMS.</td>
</tr>
<tr>
<td>At all times</td>
<td>6. Maintain records that all processes and procedures are in place and being followed.</td>
</tr>
<tr>
<td>At all times</td>
<td>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.</td>
</tr>
</tbody>
</table>

### 4. Wholesalers-distributors that distribute SILIQ must:

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be able to distribute</td>
<td>1. Establish processes and procedures to ensure that the drug is distributed only to certified pharmacies.</td>
</tr>
<tr>
<td></td>
<td>2. Train all relevant staff involved in distribution on the REMS requirements.</td>
</tr>
<tr>
<td>At all times</td>
<td>3. Distribute only to certified pharmacies.</td>
</tr>
<tr>
<td>At all times</td>
<td>4. Maintain and submit records of all drug distribution to the REMS Program.</td>
</tr>
<tr>
<td>At all times</td>
<td>5. Maintain records that all processes and procedures are in place and being followed.</td>
</tr>
<tr>
<td>At all times</td>
<td>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.</td>
</tr>
</tbody>
</table>

### 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 Reference ID: 4998927
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 (06/14/2022).

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

Reference ID: 4998927
SILIQ® REMS Prescriber Enrollment Form

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*: □ MD □ DO □ PA □ NP □ 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*: □ Email □ 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*:

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

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Reference ID: 4998927
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*:  
- Male  
- Female  
- Neutral  
- Prefer Not to Say  
Date of Birth (Month/Day/Year)*: 
Address*:  
City*:  
State*:  
Zip Code*:  
Race*:  
- African American  
- Asian  
- Caucasian  
- Hispanic  
- 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*:  
Patient Signature*:  
Date*:  

SILIQ Patient Information

- 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.

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

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SILIQ® REMS Pharmacy Enrollment Form

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)

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

Authorized Pharmacy Representative Information (*Indicates required field)

<table>
<thead>
<tr>
<th>First Name*:</th>
<th>Middle Initial:</th>
<th>Last Name*:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number*:</td>
<td>Alternate Telephone Number:</td>
<td>Office Fax*:</td>
</tr>
<tr>
<td>Email*:</td>
<td>Preferred Method of Communication*:</td>
<td>Email</td>
</tr>
<tr>
<td>Authorized Pharmacy Representative Signature*:</td>
<td>Date*:</td>
<td></td>
</tr>
</tbody>
</table>

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

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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 taking 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 taking or writing about death and dying.

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.


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Reference ID: 4998927
Public Website
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.

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)
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
Prescriber Certification
Prescribers must be certified in the SILIQ REMS to prescribe SILIQ.

SILIQ® REMS Prescriber Enrollment Form

Instructions

1. Review the SILIQ Prescribing Information.
2. Complete and submit this form below.
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.

Upon completion of these steps, the SILIQ REMS Program will notify you of successful certification via your preferred method of communication.

Required fields are denoted by "*".

SILIQ Prescriber Information

*Prescriber NPI#
Prescriber Certification
Prescribers must be certified in the SILIQ REMS to prescribe SILIQ.

SILIQ® REMS Prescriber Enrollment Form

Instructions
1. Review the SILIQ Prescribing Information.
2. Complete and submit this form below.
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.

Upon completion of these steps, the SILIQ REMS Program will notify you of successful certification via your preferred method of communication.

Required fields are denoted by ***.

SILIQ Prescriber Information
* Prescriber NPI
1020622000

* First Name

* Middle Initial

* Last Name

* Specialty

* Name of Institution or Healthcare Facility

* Street Address
123 Main St

* City
Philadelphia

* State
PA

* Zip Code
19103

* Office Phone Number

* Office Fax Number

* Mobile Phone Number

* Email

* Preferred Method of Communication

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 ensure each patient with a SILIQ REMS Patient Wallet Card and instruct each patient to carry this on 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 office 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 Agreement
* Signature

Submit
Prescriber Certification

**SILIQ® REMS Prescriber Enrollment Form submitted successfully.**

The SILIQ REMS will notify you of successful certification and when you can prescribe SILIQ.

You will receive an email containing a link to login and instructions for creating a password. Please login with the username provided. You will then be prompted to create a password.
Pharmacy Certification

All pharmacies must certify in the SILIQ REMS to participate in the distribution of SILIQ. In general, an authorized representative for a pharmacy must complete the following steps to certify in the SILIQ REMS:

- Coordinates the activities required for the pharmacy in 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*
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

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
Pharmacy Certification

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

SILIQ® REMS Pharmacy Enrollment Form

Instructions

1. Designate an authorized representative to ensure compliance with the SILIQ REMS.
2. Complete and submit this form below.

Pharmacy Identifier

Please enter NPI Number or NCPDP Number (at least one is required)

NPI Number  NCPDP Number

Continue
Pharmacy Certification

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

SILIQ® REMS Pharmacy Enrollment Form

Instructions

1. Designate an authorized representative to ensure compliance with the SILIQ REMS.
2. Complete and submit this form below.

Pharmacy Identifier

Please enter NPI Number or NCPDP Number (at least one is required)

* NPI Number:
123456789

* NCPDP Number:

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 REM 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

* Pharmacy Name:
ABC Pharmacy

* Address:
100 Main Street

* City:
Philadelphia

* State:
PA

* Zip Code:

* Phone:

* Fax:

Authorized Representative Information

* First Name:

* Middle Initial:

* Last Name:

* Telephone Number:

* Alternate Telephone Number:

* Office Fax:

* Email:

* Preferred Method of Contact (select one)

○ Fax
○ Email

☐ Signature

Submit
Pharmacy Certification

SILIQ® REMS Pharmacy Enrollment Form submitted successfully.

You will receive an email containing a link to login and instructions for creating a password. Please login with the username provided. You will then be prompted to create a password.

You will need to share the Pharmacy ID provided to you for your pharmacy staff to complete their enrollment and associate to your pharmacy.
## SILIQ Certified Pharmacy Network

The SILIQ REMS Certified Pharmacy Network list includes specialty pharmacies that are contracted to fill prescriptions for restricted distribution programs for SILIQ. All pharmacies listed are certified to dispense SILIQ.

- Download the list to spreadsheet format by clicking on the Excel icon just above the column headers.
- Search/Filter the list by entering information in the text box below any column header.
- Sort the list by clicking on any column header.

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Pharmacy Address</th>
<th>Pharmacy Phone</th>
<th>Pharmacy Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>123 Main Street</td>
<td>546-546-4545</td>
<td>564-504-5046</td>
</tr>
<tr>
<td></td>
<td>Philadelphia, PA 99999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XYZ Pharmacy</td>
<td>143 Kings Highway</td>
<td>555 555-4160</td>
<td>555 555-6140</td>
</tr>
<tr>
<td></td>
<td>Philadelphia, PA 99999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The live website will be updated, as needed, to include a list of pharmacies currently certified in the SILIQ REMS.
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. Associate to a Pharmacy
2. Certify by completing and submitting the pharmacy staff member information and attestation

Once the pharmacy staff member information and attestation is submitted successfully, an online account will be created for the pharmacy staff member.

Start Pharmacy Staff Enrollment
Pharmacy Staff Enrollment

To enroll as a pharmacy staff member, please complete the form below and click "Submit". Upon completion of these steps, the SILIQ REMS Program will notify you of your enrollment.

Required fields are denoted by "***".

SILIQ® REMS Pharmacy Staff Enrollment Form

Please contact the Authorized Representative for your pharmacy if you do not know your Pharmacy Identifier.

* Pharmacy ID

Continue
Pharmacy Staff Enrollment

To enroll as a pharmacy staff member, please complete the form below and click "Submit". Upon completion of these steps, the SILIQ REMS Program will notify you of your enrollment.

Required fields are denoted by **.

SILIQ® REMS Pharmacy Staff Enrollment Form

* Pharmacy ID

11111

Pharmacy Staff Information

You are enrolling for the below pharmacy. If this pharmacy is incorrect, please check the Pharmacy ID and if in error, click "Cancel".

11111 - ABC Pharmacy
123 Main Street
Philadelphia, PA 99999

* First Name

* Last Name

* Email Address

* Telephone Number

Alternate Telephone Number

Fax

* Preferred Method of Contact

- Email
- Telephone Number
- Fax

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.

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.
Pharmacy Staff Enrollment Confirmation

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

A confirmation of this submission has been sent to the email address provided. You can expect to receive an email containing a link to login and instructions for creating a password. Please login with the username provided. You will then be prompted to create a password.

If you do not receive the email within the next few hours, or would like to update your enrollment information at any time, please contact the SILIQ REMS for assistance at 1-855-511-6135.

To add additional pharmacies or manage your pharmacies, you may do so once you login.
Patients

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.
Contact Us

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

Phone Number
1-855-511-6135

Fax Number
1-866-227-9451

Email Address
SILIQ@SILIQREMS.com

Mailing Address
SILIQ REMS
200 Pinecrest Plaza
Morgantown, WV 26505

Program Manufacturer
Bausch Health US, LLC
Prescriber Portal
**My Patients**

Below is a list of your patients. Click "Enroll Patient" to add a new patient.

**Action Required**

- **Action Required Tasks**
  - Patient Signature Needed on Patient Enrollment Form for patient: **Melissa Jacobs**

**Patient Listing**

- Download the list in spreadsheet format by clicking the Excel icon just above the column headers.
- Search/Filter the list by entering information in the text box below any column header.
- Sort the list by clicking on any column header.

<table>
<thead>
<tr>
<th>REMS ID</th>
<th>First Name</th>
<th>Last Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Patient REMS Status</th>
<th>Prescriber Signature</th>
<th>Patient Signature</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234</td>
<td>Peggy</td>
<td>Sus</td>
<td>10/11/1995</td>
<td>Female</td>
<td><strong>ENROLLED</strong></td>
<td>[✓]</td>
<td>[✓]</td>
<td>Update Patient REMS Status</td>
</tr>
<tr>
<td>2222</td>
<td>Melissa</td>
<td>Jacobs</td>
<td>1/1/2010</td>
<td>Female</td>
<td><strong>PENDING</strong></td>
<td>[✓]</td>
<td>[✓]</td>
<td>Signature Action Required</td>
</tr>
</tbody>
</table>

Page 1 of 3 | Total Records: 55
Update Patient REMS Status Confirmation

You are about to deactivate the following Patient:

First Name: Peggy
Last Name: Sue

*Reason:
- Please Select
  - No longer on therapy
  - No longer under care
  - Deceased

dashboard. Are you sure you want to continue?

[No, do not deactivate patient] [Yes, continue to deactivate patient]
My Patients

Below is a list of your patients. Click "Enroll Patient" to add a new patient.

Action Required

- Patient Signature Needed on Patient Enrollment Form for patient: Melissa Jacobs

Enroll Patient

Please begin the enrollment process by entering patient information and clicking on "Continue".

Note: Fields marked with an * are required.

- First Name
- Last Name
- Date of Birth (MM/DD/YYYY)

[Cancel] [Continue]

Patient Listing

- Download the list to spreadsheet format by clicking the Excel icon just above the column headers.
- Search/Filter the list by entering information in the text box below any column header.
- Sort the list by clicking on any column header.

<table>
<thead>
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<th>Last Name</th>
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</tr>
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<tbody>
<tr>
<td>1234</td>
<td>Peggy</td>
<td>Sue</td>
<td>10/11/1995</td>
<td>Female</td>
<td>ENROLLED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2222</td>
<td>Melissa</td>
<td>Jacobs</td>
<td>1/1/2010</td>
<td>Female</td>
<td>PENDING</td>
<td></td>
<td></td>
<td>Update Patient REMS Status</td>
</tr>
</tbody>
</table>

[Update Patient REMS Status] [Signature Action Required]
SILQ® REMS Patient Enrollment Form

Instructions for Prescribers

1. Sign this form along with your patient.
2. Complete and submit this form below:

Required fields are denoted by an asterisk (*).

Patient Acknowledgement

By signing this form, I acknowledge that:

☐ I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILQ, and may occur at any time during treatment.

☐ I will call my doctor or the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255) if:
  - I feel new or worsening thoughts 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 are calling or writing about death and dying

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

☐ My doctor has given me a Patient Wrist Card to carry with me at all times.

☐ I understand that the SILQ REMs may contact me or my prescriber to support administration of the SILQ REMs.

Patient Information

First Name: [Name]
Middle Initial: [Initial]
Last Name: [Last Name]

Date of Birth (MM/DD/YYYY): [Date]
Gender: [Male] [Female] [Neutral] Prefer Not to Say
Race: [African American] [Asian] [Caucasian] [Hispanic] [Other (please specify)]

Email: [Email]
Phone Number: [Phone Number]

Address: [Address]
City: [City]
State: [State]
Zip Code: [Zip Code]

Patient Signature

Are you the patient currently available to complete patient signature during online enrollment?
[Yes] [No]

Signature Name: [Signature Name]

Please use your mouse or stylus to sign below.

Sign  [Signature]

Prescriber Information

First Name: [First Name]
Middle Initial: [Middle Initial]
Last Name: [Last Name]

Phone Number: [Phone Number]
NPI: [NPI Number]

Prescriber Signature

I acknowledge that prior to prescribing SILQ:

☐ 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 emerger.

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

Please use your mouse or stylus to sign below.

Sign  [Signature]
SILQ® REMS Patient Enrollment Form

Instructions for Prescribers

1. Sign this form along with your patient.
2. Complete and submit this form below.

Required fields are denoted by *. 

Patient Acknowledgement

By signing this form, I acknowledge that:

☐ I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILQ, and may occur at any time during treatment.

☐ I will call my doctor or the National Suicide Prevention Lifeline at 1-800-273-TALK (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 telling 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 SILQ REMS may contact me or my prescriber to support administration of the SILQ REMS.

Patient Information

*First Name: [Surname]

*Date of Birth (MM/DD/YYYY):

*Gender:

☐ Male ☐ Female ☐ N/A

*Race:

☐ African-American ☐ Asian

☐ Caucasian ☐ Hispanic

☐ Other (please specify)

*Email:

*Phone Number:

*Address:

*City:

*State: [Please Select]

*Zip Code:

Patient Signature

*Is the patient currently available to complete patient signature during online enrollment?

☐ Yes ☐ No

Patient will receive an email containing a link to sign this form.

If this option is selected, this patient's email is required. Please confirm the email address entered above.

Prescriber Information

First Name: Steven
Middle Initial: R
Last Name: Bits
Phone Number: 555-355-1212
NPI: 1275880752

Prescriber Signature

I acknowledge that prior to prescribing SILQ:

☐ 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 SILQ if such events occur.

Please use your mouse or stylus to sign below

Sign:

Date:

Cancer Submit
## Patient Detail

### Patient Profile

- **REMS ID:** 1234
- **First Name:** Peggy
- **Middle Initial:**
- **Last Name:** Sue
- **Date of Birth:** 10/11/1995
- **Gender:** Female
- **Race:** Caucasian

### Contact Information

- **Address:** 123 Main Street
- **City:** Philadelphia
- **State:** PA
- **Zip Code:** 19542
- **Phone Number:** 555-555-1212
- **Email:** psue@abc.com

### Patient REMS Status

- **Patient REMS Status:** ENROLLED
- **Prescriber Signature:** Signature obtained
- **Patient Signature:** Signature obtained

### Completed Patient Enrollment Form

- **Add Date:** 1/1/2022
- **Print/Download**

---

**Reference ID:** 4998927
My Patients

My Profile

Profile Details

First Name: Steven
Middle Initial:
Last Name: Meru
NP#: 1234567890
Degree: MD
Specialty: Cardiology

HEALTHCARE FACILITY INFORMATION

ABC Healthcare Facility
123 Main
Sellersville, PA 18960

Office Phone Number: 555-555-1212
Office Fax Number: 555-555-2323
Preferred Method of Communication: Email

Mobile Phone Number: 1
Email Address: smenu@abc.com

Email: SILIQ@SILIQREMS.com
Phone: 1-855-511-6135
Fax: 1-866-227-9451

Reference ID: 4998927
Pharmacy Portal
Predispose Authorization

To determine if the safe-use conditions have been met to receive SILIQ, please complete the Predispose Authorization information below and hit "Submit". The results of the Predispose Authorization will be displayed after the information is submitted.

Fields marked with * are required.

Prescriber Information

You may enter the Prescriber NPI#, Name or Address/City/State/Zip Code, then select the prescriber.

* Prescriber
1111111111 Mark Jones

Patient Information

* First Name  * Last Name  * Date of Birth  * Zip Code

Prescription Information

* Date of Service  * NDC Number  * Days Supply  * Number of Packs

Clear  Submit
Prescriber Information

You may enter the Prescriber NPI#, Name or Address/City/State/Zip Code, then select the prescriber

*Prescriber

1

111111111 Mark Jones
1212343456 Leslie Patterson

First Name

Last Name

Date of Birth

Zip Code
Predispose Authorization Results

Please review the information below. If you need to correct any information, click "Go Back".

You must generate a Predispose Authorization before dispensing SILIQ.
To generate a Predispose Authorization, click "Generate Predispose Authorization".

---

**Prescriber**

- **Prescriber REMS ID:** 12345
- **NPI:** 1234567890
- **First Name:** Mark
- **Last Name:** Jones

**Certified**

**Patient**

- **Patient REMS ID:** 9876
- **First Name:** Janet
- **Last Name:** Bowers

**Enrolled**

**Prescription**

- **Date of Fill:** 09/09/2099
- **NDC Number:** [NDC Number]
- **Days Supply:** [n]
- **Number of Packs:** [n]
Predispose Authorization Results

Please review the information below. If you need to correct any information, click "Go Back".

You must generate a Predispose Authorization before dispensing SILIQ.
To generate a Predispose Authorization, click "Generate Predispose Authorization".

Predispose Authorization generated.

Predispose Authorization: 32327

OK TO DISPENSE
REMS requirements met.

Prescriber

Prescriber REMS ID: 12345
NPI: 1234567890
First Name: Mark
Last Name: Jones

Certified

Patient

Patient REMS ID: 9876
First Name: Janet
Last Name: Bowers

Enrolled

Prescription

Date of Fill: 9999/9999
NDC Number: [NDC Number]
Days Supply: [#]
Number of Packs: [#]

New Verification
DO NOT DISPENSE
REMS requirements not met.

Prescriber
- Prescriber REMS ID: 12345
- NPI: 1234567890
- First Name: Mark
- Last Name: Jones

Patient
- Patient REMS ID: 9876
- First Name: Janet
- Last Name: Bowers

Prescription
- Date of Fill: 99/99/9999
- NDC Number: [NDC Number]
- Days Supply: [#]
- Number of Packs: [#]
Pharmacy Management

Below is a list of your associated Pharmacies and Pharmacy Staff.
To certify as an Authorized Representative at another pharmacy, click "Start Pharmacy Certification". To enroll as a Pharmacy Staff, click "Start Pharmacy Staff Enrollment".

Pharmacies

Authorized Representative

ABC Pharmacy
REMS ID: 1234
123 Main Street
Philadelphia, PA 99999
Phone: 555 555-1212
Fax: 555 555-3434
NPI #: 1234567890
Pharmacy Type: Inpatient
Status: • CERTIFIED

Pharmacy Staff

- Loretta Maybly
  REMS ID: 1234567890
  REMS Status: • ENROLLED
  Email: lmably@hcs1.com

- Steve Mason
  REMS ID: 234567890
  REMS Status: • ENROLLED
  Email: smason@hcs1.com

• Remove Association

Contact Us | Privacy Policy | Terms and Conditions
Pharmacy Management

Below is a list of your associated Pharmacies and Pharmacy Staff.
To certify as an Authorized Representative at another pharmacy, click "Start Pharmacy Certification". To enroll as a Pharmacy Staff, click "Start Pharmacy Staff Enrollment".

**Pharmacies**

- [ ] Start Pharmacy Certification
- [ ] Start Pharmacy Staff Enrollment

**Authorized Representative**

- **ABC Pharmacy**
  - **REMS ID:** 1234
  - 123 Main Street
  - Philadelphia, PA 99999
  - Phone: 555 555-1212
  - Fax: 555 555-3434
  - NPI #: 1234567890
  - Pharmacy Type: Inpatient
  - Status: [CERTIFIED]

  - **Remi Mayby**
    - **REMS ID:** 1234567890
    - **REMS Status:** [ENROLLED]
    - lmaby@hcs1.com

  - **Steve Mason**
    - **REMS ID:** 234567890
    - **REMS Status:** [ENROLLED]
    - smason@hcs1.com

  - [ ] Remove Association
Edit Pharmacy

NPI#   DEA#   NCPDP#
2222222222  948398402  87878787

Pharmacy Name: Pharmacy XYZ
Pharmacy Type: Outpatient
Address 1: 100 Broadway
City: Philadelphia
State: PA
Zip Code: 99999

Cancel  Submit
My Profile

Profile Details

Authorized Representative

First Name: Steven
Middle Initial: 
Last Name: Meru

Telephone Number: 555 555-1212
Alternate Telephone Number: 
Office Fax: 555 555-2323
Email: smenu@abc.com
Preferred Method of Communication: Email

Pharmacy Information

ABC Pharmacy
123 Broadway
Philadelphia, PA 19109

Pharmacy Type: Outpatient
NPI#: 1234567890
NCPDP#: 

Email: SILIQ@siliqrems.com
Phone: 1-800-911-6123
Fax: 1-866-227-9451
Edit Profile Details

* First Name: Steven
* Last Name: Meru

* Telephone Number: (555) 555-1212

* Office Fax: (555) 555-9999

* Email: srosen@abc.com

Preferred Method of Communication (select one):
- Fax
- Email

Cancel  Submit
PHARMACIST ASSOCIATED WITH MULTIPLE PHARMACIES
Predispose Authorization

Please select the pharmacy you wish to work with. You may enter the REMS ID, NPI, Pharmacy Name or Pharmacy Type, then select the pharmacy.

**Pharmacy**

1

- 12345 111111111 ABC Pharmacy - Inpatient
- 23456 1212343456 XYZ Pharmacy - Outpatient

Continue to Predispose Authorization
Predispose Authorization

To determine if the safe-use conditions have been met to receive SILIQ, please complete the Predispose Authorization information below and hit "Submit". The results of the Predispose Authorization will be displayed after the information is submitted.

Fields marked with * are required.

Prescriber Information
You may enter the Prescriber NPI#, Name or Address/City/State/Zip Code, then select the prescriber.

* Prescriber

Patient Information

* First Name  
* Last Name  
* Date of Birth  
* Zip Code

Prescription Information

* Date of Service  
* NDC Number  
* Days Supply  
* Number of Packs

Clear  Submit
Change Pharmacy

Please select the pharmacy you wish to work with. You may enter the REMS ID, NPI, Pharmacy Name or Pharmacy Type, then select the pharmacy.

*Pharmacy

12345 1111111111 ABC Pharmacy - Inpatient
23456 1212343456 XYZ Pharmacy - Outpatient
Pharmacy Management

Below is a list of your associated Pharmacies and Pharmacy Staff.
To certify as an Authorized Representative at another pharmacy, click "Start Pharmacy Certification". To enroll as a Pharmacy Staff, click "Start Pharmacy Staff Enrollment".

**Pharmacies**

<table>
<thead>
<tr>
<th>Authorized Representative</th>
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<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>Loretta Maybly</td>
</tr>
<tr>
<td>REMS ID: 1234</td>
<td>Steve Mason</td>
</tr>
<tr>
<td>123 Main Street</td>
<td>REIMS ID: 1234</td>
</tr>
<tr>
<td>Philadelphia, PA 99999</td>
<td>REMS Status: ENROLLED</td>
</tr>
<tr>
<td>Phone: 555 555-1212</td>
<td><a href="mailto:Lsmaybly@hcs1.com">Lsmaybly@hcs1.com</a></td>
</tr>
<tr>
<td>Fax: 555 555-3434</td>
<td>Remove Association</td>
</tr>
<tr>
<td>NPI #: 1234567890</td>
<td>Steve Mason</td>
</tr>
<tr>
<td>Pharmacy Type: Inpatient</td>
<td>REIMS ID: 234567890</td>
</tr>
<tr>
<td>Status: CERTIFIED</td>
<td>REMS Status: ENROLLED</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:lsmaybly@hcs1.com">lsmaybly@hcs1.com</a></td>
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<tbody>
<tr>
<td>Pharmacy XYZ</td>
<td>Corey Pearson</td>
</tr>
<tr>
<td>REMS ID: 4444</td>
<td></td>
</tr>
<tr>
<td>100 Broadway</td>
<td>REIMS ID: 4967890123</td>
</tr>
<tr>
<td>Philadelphia, PA 99999</td>
<td>REMS Status: ENROLLED</td>
</tr>
<tr>
<td>Phone: 555 555-8988</td>
<td><a href="mailto:corey@hcs1.com">corey@hcs1.com</a></td>
</tr>
<tr>
<td>Fax: 555 555-9999</td>
<td>Remove Association</td>
</tr>
<tr>
<td>NPI #: 2222222222</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Type: Outpatient</td>
<td></td>
</tr>
<tr>
<td>Status: CERTIFIED</td>
<td></td>
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</tbody>
</table>

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>ZZZ Pharmacy</td>
</tr>
<tr>
<td>REMS ID: 9999</td>
</tr>
<tr>
<td>1 Broadway</td>
</tr>
<tr>
<td>Philadelphia, PA 99999</td>
</tr>
<tr>
<td>Pharmacy Type: Inpatient</td>
</tr>
<tr>
<td>REMS Status: ENROLLED</td>
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