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

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)
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#

[Continue]
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

1234567890

* First Name

Jane

* Last Name

Smith

* Credentials

☐ MD  ☐ DO  ☐ PharmD  ☐ RN  ☐ NP  ☐ PA  ☐ Other (please specify)

* Name of Institution or Healthcare Facility

John Medical Center

* Street Address

123 Main St

* City

Philadelphia

* State

PA

* Zip Code

19103

* Office Phone Number

555-1234

* Office Fax Number

555-4321

* Mobile Phone Number

555-9876

* Email

jane.smith@example.com

* 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

* Signature
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 ensure appropriate handling and distribution of the medication. 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.

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

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

<table>
<thead>
<tr>
<th>NPI Number</th>
<th>NCPDP Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567890</td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>*Pharmacy Name</th>
<th>*Pharmacy Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Address</th>
<th>*State</th>
<th>*Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 Main Street</td>
<td>PA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*City</th>
<th>*Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Authorized Representative Information

<table>
<thead>
<tr>
<th>*First Name</th>
<th>Middle Initial</th>
<th>*Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Telephone Number</th>
<th>Alternate Telephone Number</th>
<th>*Office Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Preferred Method of Contact (select one)

- [x] 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, Philadelphia, PA 99999</td>
<td>540-546-4545</td>
<td>564-504-5646</td>
</tr>
<tr>
<td>XYZ Pharmacy</td>
<td>143 Kings Highway, Philadelphia, PA 99999</td>
<td>555 555-4160</td>
<td>555 555-6140</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.
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

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

* 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

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

[Instructions for logging in]

Please enter your username / email.

Username / Email

Login
Prescriber Portal
### My Patients

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

**Action Required 1**

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

**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>
<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>Sue</td>
<td>10/11/1995</td>
<td>Female</td>
<td>• ENROLLED</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>• PENDING</td>
<td>☑️</td>
<td>☑️</td>
<td>Signature Action Required</td>
</tr>
</tbody>
</table>

Page 1 of 31 | 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 1

Action Required Tasks

* 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)

[Submit button]

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>
<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>Sue</td>
<td>10/11/1995</td>
<td>Female</td>
<td>ENROLLED</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>PENDING</td>
<td></td>
<td></td>
<td>Signature Action Required</td>
</tr>
</tbody>
</table>
SILQ® REMS Patient Enrollment Form

Instructions for Prescribers

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

Required fields are denoted by **.

Patient Acknowledgement

By signing this form, I acknowledge that:

1. 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.
2. 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 talking or writing about death and dying.
3. I will call 911 if I feel an immediate threat of death or self-injury.
4. My doctor has given me a Patient Wallet Card to carry with me at all times.
5. I understand that the SILQ REMS may contact me or my prescriber to support administration of the SILQ REMS.

Patient Information

First Name: [Input field]
Middle Initial: [Input field]
Last Name: [Input field]
Date of Birth (MM/DD/YYYY): [Input field]
Gender: [Male] [Female] [Neutral]
Race: [Select race]
Email: [Input field]
Address: [Input field]
City: [Input field]
State: [Select state]
Zip Code: [Input field]
Phone Number: [Input field]

Patient Signature

Is the patient currently able to complete patient signature during online enrollment? [Yes] [No]
Signature Name: [Input field]

Prescriber Information

First Name: [Input field]
Middle Initial: [Input field]
Last Name: [Input field]
Phone Number: 955-935-1212
NPI: 1279688762

Prescriber Signature

I acknowledge that prior to prescribing SILQ:
1. 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.
2. 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 Here

Note: This is a screenshot of the SILQ REMS Patient Enrollment Form. For actual use, please refer to the original document provided.
SILIQ® 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 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 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.

Patient Information

*First Name:__
*Middle Initial:__
*Last Name:__
*Date of Birth (MM/DD/YYYY):__
*Gender:__
☐ Male  ☐ Female  ☐ Other
*Ethnicity:__
*Email:__
*Phone Number:__
*Address:__
*City:__
*State:__
*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:__
Middle Initial:__
Last Name:__
Phone Number: 555-999-1234
NPI: 123456789

Prescriber Signature

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.

Please use your mouse or stylus to sign below

[Signature]

[Submit] [Cancel]
Edit My Profile

**First Name**
Steven

**Middle Initial**

**Last Name**
Meru

**Credentials**
- [ ] DO
- [x] MD
- [ ] PharmD
- [ ] RN
- [ ] NP
- [ ] PA
- [ ] Other (please specify)

**Specialty**
Cardiology

**Name of Institution or Healthcare Facility**
ABC Healthcare Facility

**Street Address**
123 Main Street

**City**
Sellersville

**State**
PA

**Zip Code**
99999

**Office Phone Number**
555 555-1212

**Office Fax Number**
555 555-2323

**Mobile Phone Number**

**Email**
smeru@abc.com

**Preferred Method of Communication**
- [x] Email
- [ ] Fax

[Update] [Cancel]
Pharmacy Portal
Predisense Authorization

To determine if the safe-use conditions have been met to receive SILIQ, please complete the Predisense Authorization information below and hit "Submit". The results of the Predisense 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
1111111111 Mark Jones
1234343456 Leslie Patterson

*First Name

*Last Name

*Date of Birth

*Zip Code
Predisperse Authorization Results

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

You must generate a Predisperse Authorization before dispensing SILIQ.
To generate a Predisperse Authorization, click "Generate Predisperse 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: 09/09/1999
- NDC Number: [NDC Number]
- Days Supply: [x]
- Number of Packs: [x]

Contact Us | Privacy Policy | Terms and Conditions
Reference ID: 4986927
Predisense Authorization Results

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

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

Predisense Authorization generated.

Predisense Authorization: 32327

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: [h]
- Number of Packs: [#]

OK TO DISPENSE
REMS requirements met.

New Verification
## Predispense Authorization Results

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

**Prescriber**
- **REMS requirements not met.**
- Prescriber REMS ID: 12345
- NPI: 1234567890
- First Name: Mark
- Last Name: Jones
- Not Certified

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

**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
lmably@hcs1.com

Steve Mason
REMS ID: 234567890
REMS Status: ● ENROLLED
smason@hcs1.com

Remove Association
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".

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
lmably@hcs1.com

Steve Mason
REMS ID: 234567890
REMS Status: ● ENROLLED
smason@hcs1.com

Are you sure you want to remove this Staff Member from this Pharmacy?

Yes  No
<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI#</td>
<td>2222222222</td>
</tr>
<tr>
<td>DEA#</td>
<td>948398402</td>
</tr>
<tr>
<td>NCPDP#</td>
<td>87878787</td>
</tr>
<tr>
<td>Pharmacy Name</td>
<td>Pharmacy XYZ</td>
</tr>
<tr>
<td>Pharmacy Type</td>
<td>Outpatient</td>
</tr>
<tr>
<td>Address 1</td>
<td>100 Broadway</td>
</tr>
<tr>
<td>City</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>State</td>
<td>PA</td>
</tr>
<tr>
<td>Zip Code</td>
<td>99999</td>
</tr>
</tbody>
</table>

Buttons: Cancel, Submit
My Profile

Profile Details

Authorized Representative

First Name: Steven
Middle Initial: 
Last Name: Meno

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

ABC Pharmacy
123 Broadway
Philadelphia, PA 19101

Pharmacy Type: Outpatient
NPI#: 1234567890
NCPDP#: 

SILIQ® (brodalumab) injection
210 mg/1.5 mL

Prescribing Information
Medication Guide

Email: SILIQ@SILIQREMS.com
Phone: 1-866-621-6130
Fax: 1-866-227-9451

Reference ID: 4998927
Edit Profile Details

**First Name**
Steven

**Middle Initial**

**Last Name**
Meru

**Telephone Number**
(555) 555-1212

**Alternate Telephone Number**

**Office Fax**
(555) 555-9999

**Email**
sroen@abc.com

**Preferred Method of Communication (select one)**
- [ ] Fax
- [x] Email

[Submit] [Cancel]
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 1111111111 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

| 1 |

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".

<table>
<thead>
<tr>
<th>Pharamcy</th>
<th>Authorized Representative</th>
<th>Pharmacy Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pharmacy</td>
<td>Loretta Maybly</td>
<td>Steve Mason</td>
</tr>
<tr>
<td>REMS ID: 1234</td>
<td>REMS ID: 1234567890</td>
<td>REMS ID: 234567890</td>
</tr>
<tr>
<td>123 Main Street Philadelphia, PA 99999</td>
<td>REMS Status: ENROLLED</td>
<td>REMS Status: ENROLLED</td>
</tr>
<tr>
<td>Phone: 555 555-1212 Fax: 555 555-3434</td>
<td><a href="mailto:looMaybly@hcs1.com">looMaybly@hcs1.com</a></td>
<td><a href="mailto:smason@hcs1.com">smason@hcs1.com</a></td>
</tr>
<tr>
<td>NPI #: 1234567890 Pharmacy Type: Inpatient Status: CERTIFIED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Authorized Representative</th>
<th>Pharmacy Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy XYZ</td>
<td></td>
<td>Corey Pearson</td>
</tr>
<tr>
<td>REMS ID: 4444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Broadway Philadelphia, PA 99999</td>
<td>REMS ID: 4567890123</td>
<td></td>
</tr>
<tr>
<td>Phone: 555 555-8888 Fax: 555 555-9999</td>
<td>REMS Status: ENROLLED</td>
<td></td>
</tr>
<tr>
<td>NPI #: ZZZZZZZZZZZZ Pharmacy Type: Outpatient Status: CERTIFIED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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