collagenase clostridium histolyticum
REMS Program for Peyronie’s Disease

Pharmacy/Healthcare Setting Enrollment Form for Peyronie's Disease

To enroll, the pharmacy or healthcare setting must designate an Authorized Representative to coordinate the setting’s activities and assure compliance with the XIAFLEX® REMS Program for Peyronie’s disease.

To submit this form, please complete all required fields as indicated with an asterisk (*), fax completed form to XIAFLEX® at 1-877-313-1236. You will receive an enrollment confirmation within 2 business days after your form is received by Endo Pharmaceuticals. For questions regarding the XIAFLEX® REMS Program for Peyronie’s disease, call 1-877-313-1235.

AUTHORIZED REPRESENTATIVE RESPONSIBILITIES
I understand that XIAFLEX® is only available through the XIAFLEX® REMS Program for Peyronie’s disease. I am the Authorized Representative designated by my pharmacy or healthcare setting to coordinate the activities of the XIAFLEX® REMS. I agree to comply with the following program requirements:

- Ensure that the staff responsible for dispensing and administering XIAFLEX® at this healthcare setting are aware of my responsibilities as the Authorized Representative.
- Prior to dispensing XIAFLEX®, confirm that the Healthcare Provider treating Peyronie’s disease is specially certified in the XIAFLEX® REMS Program for Peyronie’s disease.
- Maintain a current list of Healthcare Providers (HCP) affiliated with my healthcare setting who are specially certified. The current affiliated Healthcare Providers of this healthcare setting include the individuals listed below. I will maintain this list by adding or removing affiliated Healthcare Providers as appropriate.
- Agree not to loan, sell or transfer XIAFLEX® to another pharmacy, healthcare setting, prescriber, institution or distributor.
- Make available to Endo Pharmaceuticals, and/or a designated third party or the FDA, documentation to verify understanding of, and adherence to, the requirements of the XIAFLEX® REMS.

I understand that this enrollment only applies to me as the designated Authorized Representative of this pharmacy or healthcare setting. I will complete a separate enrollment form for each pharmacy or healthcare setting (unique ship-to site address) for which my designation and responsibilities extend. Failure to enroll a pharmacy or healthcare setting in the XIAFLEX® REMS Program for Peyronie’s disease will result in the inability to receive shipments of XIAFLEX®.

HCP First and Last Name*  HCP Enrollment ID #*

For additional Affiliated Healthcare Setting Providers, please continue on page 2.

Authorized Representative* (Please Print)

Authorized Representative
Salutation: Dr Mr Ms Mrs
First Name*  MI  Last*  Suffix
Phone*  Fax*  Phone Type*  Main  Direct  Mobile
Email*  Preferred method of contact is:
Email  Fax
Role:* Office Staff  Clinician/Healthcare Provider  Office Administration  Other (Specify)
XIAFLEX®
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**AFFILIATED HEALTHCARE SETTING HEALTHCARE PROVIDERS**

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