

XIAFLEX®

collagenase clostridium histolyticum

REMS Program for Peyronie's Disease

Program Use Only:
Healthcare Provider Enrollment ID #

Healthcare Provider Enrollment Form for Peyronie's Disease

INSTRUCTIONS: Fax completed form to **XIAFLEX at 1-877-313-1236** or mail to XIAFLEX REMS Program, PO Box 13185, La Jolla, CA 92039. You will receive confirmation of certification within 2 business days after your form is received by Auxilium. For questions regarding the XIAFLEX REMS Program for Peyronie's disease, call 1-877-313-1235.

Healthcare Provider responsibilities for the use of XIAFLEX in the treatment of Peyronie's disease:

I understand that XIAFLEX is only available for the treatment of Peyronie's disease through the XIAFLEX REMS Program.

I confirm that to be specially certified I have met all of the following requirements:

- I am a healthcare provider knowledgeable in the management of male urological diseases.
- I have read the Prescribing Information for XIAFLEX, including the risks associated with the use of XIAFLEX and how to properly administer XIAFLEX for Peyronie's disease.
- I have completed the XIAFLEX REMS training video and/or training guide for the treatment of Peyronie's disease.
- Prior to initiating treatment, and as part of each treatment-related visit, I agree to review with and provide a copy of the Patient Counseling Tool, "What You Need to Know About XIAFLEX Treatment for Peyronie's Disease: A Patient Guide," to each patient to inform patients about the risks associated with the use of XIAFLEX and the need to follow important post-injection instructions.
- Acknowledge that my practice setting must be a certified healthcare setting, or that I will use a certified pharmacy, enrolled in the XIAFLEX REMS Program.
- I agree that I will make available to Auxilium, and/or a designated third party or the FDA, documentation to verify understanding of, and adherence to, the XIAFLEX REMS requirements.

I understand that this enrollment and certification only applies to me, and does not apply to any Healthcare Setting that employs me, or in which I may have an interest. Failure to enroll and become certified in the XIAFLEX REMS Program for Peyronie's disease as a Healthcare Provider will result in my inability to receive shipments of XIAFLEX.

Healthcare Provider Name

Signature

Date

HEALTHCARE PROVIDER INFORMATION

First Name

MI

Last

Suffix

Degree

 MD DO PA CNP

Fax

Phone

Phone Type

Office Mobile Home

Email

Preferred method of contact is:

Email Phone Fax Mail

Provide as appropriate:

NPI #

ME #

License # and State

Specialty: General Surgeon Plastic Surgeon Urologist Other (specify)

PRACTICE INFORMATION

Practice Name

Address

City

State

Zip

Primary Treatment Setting: Inpatient Outpatient/Clinic (not affiliated with hospital) Outpatient/Clinic (affiliated with hospital)