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 2957, Phoenix, AZ 85062-2957. You will receive confirmation of certification 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.

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 Endo Pharmaceuticals, 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)

