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

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 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.
- I 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

Phone* | Fax* | Phone Type*

☐ Office ☐ Mobile ☐ Home

Email* | Preferred method of contact* is:

☐ Email ☐ Fax

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)

