XIAFLEX®

☐ NEW Enrollment
☐ Enrollment Update

collagenase clostridium histolyticum

REMS Program for Peyronie's Disease

Program Use Only:
Healthcare Setting Enrollment ID #

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 is 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.

SETTING INFORMATION

Healthcare Setting Name*

Ship-to Address*

City*

State*

ZIP*

Setting Phone*

Setting Fax*

Provide as appropriate:

NPI # (facility NPI)*

HIN #

NCPDP #

Pharmacy or Healthcare Setting Type* (Check one)

☐ Independent Practice
☐ Group Practice
☐ Institution Central Purchasing (owned or under the control of hospital system)
☐ Institution Direct Purchasing (owned or under the control of hospital system)
☐ Pharmacy

Authorized Representative* (Please Print)

Signature*

Date*

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)

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AFFILIATED HEALTHCARE SETTING HEALTHCARE PROVIDERS

HCP First and Last Name	HCP Enrollment ID #

