SILIQ™
(brodalumab) injection
210 mg/1.5 mL

SILIQ™ REMS Program
Prescriber Enrollment Form

Instructions

Please fax this completed form to the SILIQ Risk Evaluation Mitigation Strategy (REMS) Program at 1-866-227-9451, submit online at www.SILIQREMS.com, or email it to SILIQ@SILIQREMS.com.

SILIQ (brodalumab) is available only through the SILIQ REMS Program. The SILIQ REMS Program is available to answer questions regarding this program and initiating treatment with SILIQ. Please call 1-855-511-6135 for more information.

Only prescribers, pharmacies, and patients enrolled in the SILIQ REMS Program are able to prescribe, dispense and receive SILIQ.

1. Review the one-time SILIQ REMS Enrollment Information for Prescribers, including the Prescribing Information (PI).
2. Complete and submit this *SILIQ REMS Program Prescriber Enrollment Form* via the program website, email, or the fax number provided.
3. Send your patient's prescription to a pharmacy that is enrolled in the SILIQ REMS Program by utilizing the Pharmacy Certification Look Up function on the SILIQ REMS Program website.

You will receive enrollment confirmation via your preferred method of communication (email or fax) within 2 business days.

SILIQ Prescriber Information (*Required)

First Name*:	Last Name*:	Degree*: ❒ MD ❒ DO ❒ PA ❒ NP ❒ Other
National Provider Identification (NPI) Number*:	DEA Number:	
Name of Institution or Healthcare Facility*:		Specialty*:
Street Address*:		
City*:	State*:	Zip Code*:
Office Phone Number*:	Office Fax Number*:	Mobile Phone Number:
Email Address:	Preferred Method of Communication*: ❒ Email ❒ Fax	

Prescriber Agreement

By completing this form, I attest that:

1. I have read and understand the SILIQ Prescribing Information.
2. I understand that I must comply with the Program requirements in order to prescribe SILIQ.
3. I understand that by signing this *SILIQ REMS Program Prescriber Enrollment Form* (one time only), I will be enrolled in the SILIQ REMS Program and may prescribe SILIQ.
4. I understand that, prior to authorizing the first prescription, I am responsible for counseling each patient that suicidal ideation and behavior (SIB), including completed suicides, have occurred in patients treated with SILIQ. I will inform the patient of the following key safety information:
    - Suicidal ideation and behavior (SIB) events and symptoms may occur at any time during treatment with SILIQ.
    - To be aware of symptoms of suicidal ideation behavior (SIB) events and steps to take if SIB symptoms occur.
5. I understand that I must submit a completed *SILIQ REMS Program Patient-Prescriber Agreement Form* for each patient before I prescribe SILIQ for the first time, and store a copy of the completed form in the patient's record.
6. I will provide each patient with a *SILIQ REMS Program Patient Wallet Card* and instruct each patient to carry this card with them at all times.
7. I understand that patients with new or worsening symptoms of depression or suicidality should be referred to a mental health professional, as appropriate.
8. I will inform the SILIQ REMS Program if an enrolled patient has discontinued therapy or is no longer under my care.
9. I understand Valeant and its agents may contact me via phone, mail, fax, email, or in person to support administration of the SILIQ REMS Program.

Prescriber Signature*:	Date*:

Reference ID: 4109073