SILIQ™
(brodalumab) injection
210 mg/1.5 mL

SILIQ™ REMS Program
Pharmacy Enrollment Form

Instructions

To become enrolled, the pharmacy must designate an Authorized Pharmacy Representative to ensure compliance with the SILIQ Risk Evaluation and Mitigation Strategy (REMS) Program.

Please fax this completed form to the SILIQ 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.

Authorized Pharmacy Representative Responsibilities

I am the authorized representative designated by my pharmacy to coordinate the activities of the SILIQ REMS Program. By signing this form, I agree, on behalf of myself and my pharmacy, to comply with the following program requirements:

1. I understand that by signing this form, and upon confirmation from the SILIQ REMS Program, this pharmacy will be enrolled in the SILIQ REMS Program, and will be able to order and dispense SILIQ.
2. This pharmacy will re-enroll in the SILIQ REMS Program if the name and contact information for the Authorized Pharmacy Representative changes.
3. This pharmacy will ensure that all relevant staff involved in the dispensing of SILIQ is trained on the SILIQ REMS Program requirements.
4. This pharmacy will maintain and make available appropriate documentation reflecting that all processes and procedures are in place and being followed.
5. I understand that non-compliance with the requirements of the SILIQ REMS Program will result in decertification of my pharmacy and termination of authorization to dispense SILIQ.
6. I will ensure that, prior to dispensing SILIQ, my pharmacy will verify that the prescriber is certified and the patient is enrolled to receive SILIQ by contacting the SILIQ REMS Program.
7. This pharmacy will comply with audits by Valeant, the US Food and Drug Administration (FDA), or a designated third party acting on behalf of Valeant or FDA to ensure compliance with the SILIQ REMS Program.

Pharmacy Information (*Required)

Pharmacy Name*:		Pharmacy Type*: ❒ Inpatient ❒ Outpatient		
Address*:		City*:	State*:	Zip Code*:
Pharmacy Identifier* (at least one required):	NPI:	NCPDP:	DEA:	

Authorized Pharmacy Representative Information (*Required)

First Name*:	Last Name*:	MI:
Telephone Number*:	Alternate Telephone Number:	Office Fax*:
Email*:	Preferred Method of Communication*: ❒ Email ❒ Fax	
Authorized Pharmacy Representative Signature*:		Date*:

By completing and submitting this form and receiving enrollment confirmation, your pharmacy will be certified in the SILIQ REMS Program. You will receive confirmation of your enrollment via your preferred method of communication.