

*This document is current as of June 1, 2013. It may not reflect the latest approved REMS.*

## **Prescriber Certification Requirements**

The following is a list of REMS with certification of prescribers and the requirements that prescribers must meet in order to become certified, based on the REMS document.

### **Aranesp**

1. To become specially certified, HCPs must enroll into the ESA APPRISE Oncology Program by doing the following:
  1. Review the full prescribing information which includes the Medication Guide.
  2. Complete the ESA APPRISE Oncology Program Training Module for Healthcare Providers.
  3. Complete and sign the ESA APPRISE Oncology Program Enrollment Form for Healthcare Providers and submit it to the ESA APPRISE Oncology Program Call Center.
  4. As a prescriber, agree to provide and review the Medication Guide with the oncology patient or patient representative at the initiation of each new course of ESA therapy. After initiation of treatment, and for as long as treatment continues, provide an Aranesp Medication Guide to each oncology patient once a month during regular office visits—or, if regular office visits occur less frequently than once a month, at the next regularly scheduled office visit.
  5. Agree to send a completed signed copy of the ESA APPRISE Oncology Program Patient and Healthcare Professional (HCP) Acknowledgment Form (or modified version consistent with the allowable changes) to the ESA APPRISE Oncology Program Call Center and retain a copy for his/her records.

### **Caprelsa**

1. To become certified to prescribe CAPRELSA, prescribers will be required to enroll in the CAPRELSA REMS Program and must:
  1. Review the CAPRELSA REMS HCP Education Pamphlet or Slide Set and the Full Prescribing Information which includes the Medication Guide.
  2. Complete the Prescriber Training.
  3. Complete and sign the CAPRELSA Prescriber Enrollment Form and submit it to the CAPRELSA REMS Program.

### **Epogen / Procrit**

1. To become specially certified, HCPs must enroll into the ESA APPRISE Oncology Program by doing the following:
  1. Review the full prescribing information which includes the Medication Guide.
  2. Complete the ESA APPRISE Oncology Program Training Module for Healthcare Providers.
  3. Complete and sign the ESA APPRISE Oncology Program Enrollment Form for Healthcare Providers and submit it to the ESA APPRISE Oncology Program Call Center.
  4. As a prescriber, agree to provide and review the Medication Guide with the oncology patient or patient representative at the initiation of each new course of ESA therapy. After initiation of treatment, and for as long as treatment continues, provide an Epogen/Procrit Medication Guide to each oncology patient once a month during regular office visits—or, if regular office visits

occur less frequently than once a month, at the next regularly scheduled office visit.

5. Agree to send a completed signed copy of the ESA APPRISE Oncology Program Patient and Healthcare Professional (HCP) Acknowledgment Form (or modified version consistent with the allowable changes) to the ESA APPRISE Oncology Program Call Center and retain a copy for his/her records.

## **Isotretinoin**

1. To become certified, each prescriber must activate registration, by completing the Prescriber Enrollment Form, via the iPLEDGE website or the automated phone system. The registration and activation requires each prescriber to agree to do the following:
  1. Register each patient in the iPLEDGE Program via the iPLEDGE website or automated phone system.
  2. Understand the risks of fetal exposure to isotretinoin and the risk factors for unplanned pregnancy.
  3. Correctly identify and document patients as females of childbearing potential, females not of childbearing potential, or males.
  4. Provide contraception counseling to females of childbearing potential prior to and during isotretinoin treatment, or refer females of childbearing potential to an expert for such counseling.
  5. Provide scheduled pregnancy testing for females of childbearing potential and then verify and document the negative pregnancy test result prior to writing each prescription.
  6. Document the two chosen forms of contraception for each female of childbearing potential prior to writing each prescription.
  7. Prescribe no more than a 30-day supply of isotretinoin with no refills.
  8. Report any pregnancies in patients prescribed isotretinoin to iPLEDGE.

## **Juxtapid**

1. To become specially certified to prescribe JUXTAPID, prescribers must enroll in JUXTAPID REMS program. Prescribers must complete the following requirements:
  1. Review the Prescribing Information (PI)
  2. Complete the Prescriber Training Module
  3. Complete and sign the Prescriber Enrollment Form and submit it to the JUXTAPID REMS Program.

## **Kynamro**

1. To become specially certified to prescribe KYNAMRO, prescribers must enroll in the KYNAMRO REMS Program. Prescribers must complete the following requirements:
  1. Review the Prescribing Information (PI).
  2. Complete the KYNAMRO REMS prescriber training by reviewing the materials in the KYNAMRO REMS Prescriber Education and Enrollment Kit.
  3. Complete and sign the Prescriber Enrollment Form and submit it to the KYNAMRO REMS Program.

## **Letairis**

1. Gilead will ensure that, to become certified, each prescriber agrees, on the Prescriber Enrollment and Agreement Form, that he or she has read the full prescribing information (PI) and Medication Guide for LETAIRIS. The physician further agrees that he or she will:
  1. Enroll all patients who take LETAIRIS in the REMS program.
  2. Re-enroll patients into the REMS program annually.
  3. Review the LETAIRIS Medication Guide and Patient Enrollment Guide with every patient.
  4. For women, determine whether each woman is of childbearing potential as defined in the Prescriber Enrollment and Agreement Form before enrolling her in the REMS and monitor each woman for changes in childbearing potential status.
  5. For women of childbearing potential:
    1. Educate patients about the risk of teratogenicity and the need to use highly reliable contraception as defined in the Prescriber Enrollment and Agreement Form during LETAIRIS treatment and for one month following treatment discontinuation.
    2. Order and review pregnancy tests prior to initiation of LETAIRIS treatment and monthly during treatment.
    3. Counsel the patient if the patient is not complying with the required testing or if she is not using appropriate contraception.
  6. Report any adverse events and any pregnancy during LETAIRIS treatment to Gilead with all available information required for the FDA Form 3500A.

## **Lotronex**

1. To become certified, each prescriber enrolls into the Prescribing Program for LOTRONEX by submitting a completed Prescriber Enrollment Form and attesting to the following:
  1. I request to participate in the Prescribing Program for LOTRONEX and acknowledge that I have read and understand the complete Prescribing Information and other enrollment materials for LOTRONEX. I understand the risks associated with its use and will follow the requirements of the Prescribing Program for LOTRONEX described below. I understand the importance of reporting all cases of ischemic colitis and serious complications of constipation to Prometheus at 1-888-423-5227.
  2. I understand that LOTRONEX is approved only for women with severe, diarrhea-predominant irritable bowel syndrome who have: •chronic irritable bowel syndrome symptoms (generally lasting for 6 months or longer), •had anatomic or biochemical abnormalities of the gastrointestinal tract excluded, and •not responded adequately to conventional therapy. Diarrhea-predominant irritable bowel syndrome is severe if it includes diarrhea and one or more of the following: •frequent and severe abdominal pain and discomfort, •frequent bowel urgency or fecal incontinence, •disability or restriction of daily activities due to irritable bowel syndrome.
  3. I understand that if I prescribe LOTRONEX for my patient(s), I must be able to perform the following:
    1. diagnose and manage irritable bowel syndrome, ischemic colitis, constipation, and complications of constipation or refer patients to a specialist as needed.
    2. ensure that all patients under my care are educated by me or a healthcare provider in my practice about the benefits and risks of the drug.
  4. I agree to:
    1. provide each of my patients with a copy of the LOTRONEX Medication Guide at initiation of LOTRONEX treatment.
    2. review the content of the Medication Guide and encourage the patient to read it and ask

questions.

3. have each patient sign the Patient Acknowledgement Form. The original signed form must be placed in the patient's medical record, and a copy given to the patient.
4. inform my patients about the Patient Follow-Up Survey, encourage them to participate and provide them with a Patient Follow-Up Survey Pre-Enrollment Form.
5. affix Prescribing Program for LOTRONEX program stickers to written prescriptions for LOTRONEX (i.e., the original and all subsequent prescriptions). Stickers will be provided as part of the Prescribing Program for LOTRONEX. Refills are permitted to be written on prescriptions.
6. ensure that all prescriptions for LOTRONEX are written and not transmitted by telephone, facsimile, or computer.

## **Lumizyme**

1. To become certified into the Lumizyme ACE Program, each healthcare professional must complete the training and enroll in the Lumizyme ACE Program by submitting a completed Prescriber Enrollment and Attestation Form attesting to the following:
  1. I have completed educational training about Lumizyme (alglucosidase alfa) and understand the risks and benefits of Lumizyme.
  2. I understand that Lumizyme is indicated for patients 8 years and older with late (non-infantile) onset Pompe disease who do not have evidence of cardiac hypertrophy. The safety and efficacy of Lumizyme have not been evaluated in controlled clinical trials in infantile-onset patients or in late-onset disease patients less than 8 years of age.
  3. I understand that by completing the training program and signing this attestation form, I am now enrolled in the Lumizyme ACE Program and can prescribe and administer Lumizyme.
  4. I understand that I must enroll all patients being treated with Lumizyme into the Lumizyme ACE Program by completing a Patient Enrollment and Acknowledgement Form.
  5. I understand that I am responsible for providing the Patient Enrollment and Acknowledgement Form to patients (or, as appropriate, their parents/guardians) and for obtaining their signature on the Patient Enrollment and Acknowledgement Form prior to initiating them on treatment with Lumizyme.
  6. I will advise patients and caregivers about the known (e.g., anaphylaxis and severe allergic reactions) and potential risks (e.g., severe cutaneous and systemic immune mediated reactions) associated with administration of Lumizyme and will review the risks and benefits of Lumizyme as per the product labeling.
  7. I understand that patients may experience anaphylaxis or severe allergic reactions to Lumizyme and I have access to appropriate medical support measures.
  8. I understand that I will be required to sign a Prescriber Enrollment and Attestation Form on an annual basis to maintain my enrollment in the Lumizyme ACE Program and to prescribe Lumizyme.

## **Mifeprex**

1. To become specially certified, each prescriber must complete and fax to the MIFEPREX distributor the one-time Prescriber's Agreement, agreeing that they meet the qualifications and will follow the guidelines outlined in the Prescriber's Agreement.

## Pomalyst

1. To become certified, each prescriber must complete the Prescriber Enrollment Form and agree to do the following:
  1. Provide patient counseling on the benefits and risks of POMALYST therapy, including risks described in the BOXED WARNINGS.
  2. Enroll each patient by completing and submitting to the Celgene Customer Care Center via mail (86 Morris Avenue, Summit, NJ 07901), email (customer care@celgene.com), fax (1-888-432-9325), or online (www.celgeneriskmanagement.com), a signed Patient-Physician Agreement Form (PPAF) identifying the patient's risk category (see PPAFs for all six risk categories) for each new patient. In signing the PPAF, each prescriber acknowledges that they understand that POMALYST is available only through the POMALYST REMSTM program, and that they must comply with program requirements.
  3. Provide contraception and emergency contraception counseling with each new prescription prior to and during POMALYST treatment.
  4. Provide scheduled pregnancy testing for females of reproductive potential and verify negative pregnancy test results prior to writing a new prescription or subsequent prescriptions.
  5. Report any pregnancies in female patients or female partners of male patients prescribed POMALYST immediately to Celgene Drug Safety (or Celgene Customer Care Center (1-888-423-5436)).
  6. Complete a prescriber survey (phone or online) for every patient (new and follow-up), obtain a unique prescription authorization number for each prescription written, and include this authorization number on the prescription. The authorization number can be obtained by contacting the Celgene Customer Care Center, using the automated IVR system, or via the www.CelgeneRiskManagement.com website. o For females of reproductive potential, authorization numbers are valid only for 7 days from date of last pregnancy test. o Authorization numbers are valid for 30 days from the date it is issued for all other patients.
  7. Facilitate compliance with the mandatory POMALYST REMSTM patient survey by instructing patients to complete the mandatory surveys (phone or online) at program specified frequencies.
  8. Prescribe no more than a 4-week (28-day) supply, with no automatic refills or telephone prescriptions.
  9. Contact a pharmacy certified by the POMALYST REMSTM program to fill the POMALYST prescription.
  10. Return all unused POMALYST brought in by patients to Celgene Customer Care.
  11. Re-enroll patients in the POMALYST REMSTM program if POMALYST is required and previous therapy with POMALYST has been discontinued for 12 consecutive months.

## Revlimid

1. To become certified, each prescriber must complete the Prescriber Enrollment Form and agree to do the following:
  1. Provide patient counseling on the benefits and risks of REVLIMID therapy, including risks described in the BOXED WARNINGS.
  2. Enroll each patient by completing and submitting to the Celgene Customer Care Center via mail (86 Morris Avenue, Summit, NJ 07901), email (customer care@celgene.com), fax (1-888-4329325), or online (www.celgeneriskmanagement.com), a signed Patient-Physician Agreement Form (PPAF) identifying the patient's risk category (see PPAFs for all six risk

categories) for each new patient. In signing the PPAF, each prescriber acknowledges that they understand that REVLIMID is available only through the REVLIMID REMS™ program, and that they must comply with program requirements.

3. Provide contraception and emergency contraception counseling with each new prescription prior to and during REVLIMID treatment.
4. Provide scheduled pregnancy testing for females of reproductive potential and verify negative pregnancy test results prior to writing a new prescription or subsequent prescriptions.
5. Report any pregnancies in female patients or female partners of male patients prescribed REVLIMID immediately to Celgene Drug Safety (or Celgene Customer Care Center, 1-888423-5436).
6. Complete a prescriber survey (phone or online) for every patient (new and follow-up), obtain a unique prescription authorization number for each prescription written, and include this authorization number on the prescription. The authorization number can be obtained by contacting the Celgene Customer Care Center, using the automated IVR system, or via the [www.CelgeneRiskManagement.com](http://www.CelgeneRiskManagement.com) website. o For females of reproductive potential, authorization numbers are valid only for 7 days from date of last pregnancy test and 30 days from the date it is issued for all other patients.
7. Facilitate compliance with the mandatory REVLIMID REMS™ program patient survey by instructing patients to complete the mandatory surveys (phone or online) at program specified frequencies.
8. Prescribe no more than a 4-week (28-day) supply, with no automatic refills or telephone prescriptions.
9. Contact a REVLIMID REMS™ program pharmacy certified by the REVLIMID REMS™ program to fill the REVLIMID prescription.
10. Return all unused REVLIMID brought in by patients to Celgene Customer Care.
11. Re-enroll patients in the REVLIMID REMS™ program if REVLIMID is required and previous therapy with REVLIMID has been discontinued for 12 consecutive months.

## **Rosiglitazone**

1. To become specially certified to prescribe rosiglitazone, prescribers will be required to enroll in the Rosiglitazone REMS Program and must:
  1. Review the Rosiglitazone REMS Prescriber Overview and the Full Prescribing Information, including the Medication Guide.
  2. Complete and sign the Rosiglitazone REMS Prescriber Enrollment Form and submit it to the Rosiglitazone REMS Program.
  3. Agree to complete and sign a Rosiglitazone REMS Patient Enrollment Form for each patient enrolled.
  4. Agree to provide and review the Medication Guide for the prescribed rosiglitazone medicine with the patient or caregiver.
  5. Agree to provide a completed, signed copy of the Rosiglitazone REMS Patient Enrollment Form to the patient, retain a copy for your records, and submit a copy to the Rosiglitazone REMS Program.

## **Sabril**

1. Lundbeck Inc. will ensure that, to become certified, prescribers attest to their understanding of the

REMS program requirements and the risks associated with Sabril, and that prescribers commit to the following:

1. Reading the full prescribing information (PI) and Medication Guide;
2. Having knowledge of the approved indications for Sabril;
3. Having experience in treating epilepsy;
4. Having knowledge of the risks of Sabril, especially vision loss;
5. If prescribing for infantile spasms, having knowledge of the risk of MRI abnormalities with use of Sabril;
6. Assessing the effectiveness of Sabril within 2-4 weeks in infants and children (<3 years of age) and within 12 weeks in children (≥3 years of age), adolescent, and adults; in the case that insufficient clinical benefit has occurred, Sabril will be discontinued; for patients discontinuing Sabril at this evaluation, a Treatment Maintenance Form will not be completed; for patients continuing treatment, a Treatment Maintenance Form will be completed and faxed to the REMS coordinating center;
7. Ordering and reviewing visual assessment at the time of initiation of Sabril using the Ophthalmologic Assessment Form (with the baseline assessment to be conducted within 4 weeks of starting Sabril), and every 3 months after initiating Sabril therapy; the Ophthalmologic Assessment Form will be faxed to the REMS coordinating center;
8. Educating patients on the risks and benefits of Sabril;
9. Enrolling all patients who take Sabril in the REMS program by completing and submitting the Treatment Initiation Form and the Patient/Parent/Legal Guardian-Physician Agreement Form;
10. Reviewing the Sabril Medication Guide with every patient;
11. Counseling the patient if the patient is not complying with the required vision monitoring beyond the baseline test, and removing the patient from therapy if the patient still fails to comply with required vision monitoring;
  1. Should discontinuation be required, discontinuation will be accomplished by tapering the patient from therapy as described in the Dear HCP Medication Taper Letter; and
12. Reporting to the Sponsor at 1-800-455-1141 any serious adverse events with Sabril and providing all known details of the event.

## **Soliris**

1. Prescriber certification is based on prescriber agreement that the prescriber will:
  1. Counsel patients and provide the patient educational materials to the patient, including the Soliris Patient Safety Card and the Medication Guide
  2. Provide the Medication Guide to the patient prior to each infusion
  3. Review the educational materials (Soliris Patient Safety Card, Prescriber Introductory Letter, Prescriber Safety Brochure, Important Safety Information about Soliris, Patient Safety Brochure, Important Safety Information about SoUris, and Dosing and Administration Guide) and the product labeling and comply with the directions for safe use including ensuring patients receive a meningococcal vaccine.
  4. Promptly report to the Sponsor at 1-888-765-4747 or to the FDA at 1-800-3321088 cases of meningococcal infection, including the patients' clinical outcomes

## **Thalomid**

1. To become certified, each prescriber must complete the Prescriber Enrollment Form and agree to do the

following:

1. Provide patient counseling on the benefits and risks of THALOMID therapy, including the risks described in the **BOXED WARNINGS**.
2. Enroll each patient by completing and submitting to the Celgene Customer Care Center via mail (86 Morris Avenue, Summit, NJ 07901), email (customer care@celgene.com), fax (1-888-432-9325) or online (www.celgeneriskmanagement.com), a signed Patient- Physician Agreement Form (PPAF) identifying the patient's risk category (see PPAFs for all six risk categories) for each new patient. In signing the PPAF, each prescriber acknowledges that they understand that THALOMID is available only through the THALOMID REMSTM program, and that they must comply with program requirements.
3. Provide contraception and emergency contraception counseling with each new prescription prior to and during THALOMID treatment.
4. Provide scheduled pregnancy testing for females of reproductive potential and verify negative pregnancy test results prior to writing a new prescription or subsequent prescriptions.
5. Report any pregnancies in female patients or female partners of male patients prescribed THALOMID immediately to Celgene Drug Safety (or Celgene Customer Care Center (1-888-423-5436)).
6. Complete a prescriber survey (phone or online) for every patient (new and follow-up), obtain a prescription authorization number for each prescription written, and include this authorization number on the prescription. The authorization number can be obtained by contacting the Celgene Customer Care Center, using the automated IVR system, or via the www.CelgeneRiskManagement.com website. For females of reproductive potential, authorization numbers are valid only for 7 days from date of last pregnancy test and 30 days from the date it is issued for all other patients.
7. Facilitate compliance with a mandatory THALOMID REMSTM patient survey by instructing patients to complete the mandatory surveys (phone or online) at program specified frequencies.
8. Prescribe no more than a 4-week (28-day) supply, with no automatic refills or telephone prescriptions.
9. Contact a pharmacy certified by the THALOMID REMSTM program to fill the THALOMID prescription.
10. Return all unused THALOMID brought in by patients to Celgene Customer Care.
11. Re-enroll patients in the THALOMID REMSTM program if THALOMID is required and previous therapy with THALOMID has been discontinued for 12 consecutive months.

## **Tikosyn**

1. To become certified, each prescriber will enroll in the Tikosyn Program by submitting to Pfizer a completed Prescriber Certification Form, and agreeing to the following:
  1. I understand that patients initiated or re-initiated on Tikosyn should be admitted for a minimum of 3 days to a healthcare facility that can provide calculations of creatinine clearance, continuous electrocardiographic monitoring, and cardiac resuscitation;
  2. I understand that following the treatment initiation and dosing guidelines in the Tikosyn label will decrease the risk of Tikosyn induced arrhythmia;
  3. I will inform my patients that Tikosyn is associated with the risk of induced arrhythmias;
  4. I will inform my patients that their blood lab measures and ECG should be reevaluated every 3 months;
  5. I will provide the Tikosyn Medication Guide to each patient at the initiation and reinitiation of



Tikosyn therapy. I will review the contents of the Medication Guide with each patient.

## **TIRF**

1. To become certified to prescribe TIRF medicines, prescribers will be required to enroll in the TIRF REMS Access program. Prescribers must complete the following requirements to be enrolled:
  1. Review the TIRF REMS Access education materials (TIRF REMS Access Education Program), including the Full Prescribing Information (FPI) for each TIRF medicine, and successfully complete the Knowledge Assessment (Knowledge Assessment).
  2. Complete and sign the Prescriber Enrollment Form. In signing the Prescriber Enrollment Form, each prescriber is required to acknowledge the following:
    1. I have reviewed the TIRF REMS Access Education Program, and I have completed the Knowledge Assessment. I understand the responsible use conditions for TIRF medicines and the risks and benefits of chronic opioid therapy.
    2. I understand that TIRF medicines can be abused and that this risk should be considered when prescribing or dispensing TIRF medicines in situations where I am concerned about an increased risk of misuse, abuse, or overdose, whether accidental or intentional.
    3. I understand that TIRF medicines are indicated only for the management of breakthrough pain in patients with cancer, who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent pain.
    4. I understand that TIRF medicines are contraindicated for use in opioid nontolerant patients, and know that fatal overdose can occur at any dose.
    5. I understand that TIRF medicines must not be used to treat any contraindicated conditions described in the FPI, such as acute or postoperative pain, including headache/migraine.
    6. I understand that converting patients from one TIRF medicine to a different TIRF medicine must not be done on a microgram-per-microgram basis. I understand that TIRF medicines are not interchangeable with each other, regardless of route of administration, and that conversion may result in fatal overdose, unless conversion is done in accordance with labeled product-specific conversion recommendations (refer to the 'List of TIRF Medicines Available only through the TIRF REMS Access program' in Attachment 1). Note, a branded TIRF medicine and its specific generic product(s) are interchangeable.
    7. I understand that the initial starting dose for TIRF medicines for all patients is the lowest dose, unless individual product labels provide product-specific conversion recommendations, and I understand that patients must be titrated individually.
    8. I will provide a Medication Guide for the TIRF medicine that I intend to prescribe to my patient or their caregiver and review it with them. If I convert my patient to a different TIRF medicine, the Medication Guide for the new TIRF medicine will be provided to, and reviewed with, my patient or their caregiver.
    9. I will complete and sign a TIRF REMS Access Patient-Prescriber Agreement Form with each new patient, before writing the patient's first prescription for a TIRF medicine, and renew the agreement every two (2) years.
    10. I will provide a completed, signed copy of the Patient-Prescriber Agreement Form to the patient and retain a copy for my records. I will also provide a completed, signed copy to the TIRF REMS Access program (through the TIRF REMS Access website or by fax) within ten (10) working days.
    11. At all follow-up visits, I agree to assess the patient for appropriateness of the dose of the TIRF medicine, and for signs of misuse and abuse.

12. I understand that TIRF medicines are only available through the TIRF REMS Access program. I understand and agree to comply with the TIRF REMS Access program requirements for prescribers.
13. I understand that I must re-enroll in the TIRF REMS Access program and successfully complete the enrollment requirements every two (2) years.

## **Tracleer**

1. Actelion will ensure that each prescriber agrees, on the Prescriber Certification section of the Tracleer Enrollment for Patients and Prescribers form or the Prescriber Certification Form that he or she has read and understood the Tracleer Prescriber Essentials training guide and documented that he or she:
  1. Has enrolled patients in the REMS program (the Tracleer Access Program [T.A.P.®]), and documented each enrollment.
  2. Has reviewed and discussed the Medication Guide and the risks of bosentan (including the risks of teratogenicity and hepatotoxicity) with their patients prior to prescribing Tracleer
  3. Has reviewed pretreatment liver function tests and confirmed that Female patients of Child Bearing Potential (FCBP) are not pregnant
  4. Has ordered and will monitor monthly liver tests and for FCBP, pregnancy tests
  5. Has educated and counseled any FCBP to notify the prescriber if she suspects she might be pregnant
  6. Has educated and counseled any FCBP about the need to use reliable methods of contraception during treatment with Tracleer and for one month after treatment discontinuation
  7. Will notify Actelion of any adverse events, including hepatotoxicity, and to report any pregnancy during treatment with Tracleer
  8. Will counsel patients who fail to comply with program requirements
  9. For patients continuing therapy, will re-enroll patients into the REMS program after the first 12 months of treatment then annually thereafter

## **Tysabri**

1. To become certified, prescribers will be required to enroll in the TOUCH® Prescribing Program by completing the following requirements:
  1. Review the TYSABRI REMS prescriber educational materials, including the full Prescribing Information.
  2. Complete and sign the Prescriber/Patient Enrollment Form and acknowledge the following:
    1. I have read and understand the full Prescribing Information for TYSABRI
    2. I understand that TYSABRI increases the risk of progressive multifocal leukoencephalopathy (PML), an opportunistic viral infection of the brain that usually leads to death or severe disability
    3. I am aware that cases of PML have been reported in patients taking TYSABRI who were recently or concomitantly treated with immunomodulators or immunosuppressants, as well as in patients receiving TYSABRI monotherapy
    4. I understand that the following three risk factors have been associated with increased risk of PML in TYSABRI-treated patients: - Longer treatment duration, especially beyond 2 years - Prior treatment with an immunosuppressant (e.g., mitoxantrone, azathioprine, methotrexate, cyclophosphamide, mycophenolate mofetil) - The presence of anti-JCV antibodies. The risks and benefits of continuing treatment with TYSABRI should be

carefully considered in patients who are found to be anti-JCV antibody positive and have one or more additional risk factors.

5. To my knowledge, this patient has no known contraindications to TYSABRI, including PML
6. I have instructed this patient to promptly report to me any new or worsening symptoms that persist over several days, especially nervous system symptoms
7. I understand that this patient should be seen and evaluated 3 months after the first infusion, 6 months after the first infusion, at least every 6 months thereafter for as long as this patient receives TYSABRI, and for at least 6 months after TYSABRI has been discontinued
8. I will determine every 6 months whether this patient should continue on TYSABRI and, if so, authorize treatment for another 6 months
9. I understand that I am required to submit a Patient Discontinuation Questionnaire when patients have discontinued TYSABRI treatment
10. I should report to Biogen Idec, as soon as possible, cases of PML, hospitalizations due to opportunistic infection, or deaths
11. I understand that data concerning this patient and me will be entered into the mandatory TOUCH Prescribing Program. Biogen Idec requires my cooperation with periodic data collection. Failure to provide the requested information or otherwise comply with the requirements of the TOUCH Prescribing Program may result in discontinuation of TYSABRI treatment for this patient and termination of my authorization to prescribe TYSABRI
12. I have received educational materials regarding the benefits and risks of TYSABRI treatment
13. I have, or another healthcare provider under my direction has, educated this patient on the benefits and risks of treatment with TYSABRI, provided him or her with the Patient Medication Guide and Enrollment Form, instructed him or her to read these materials, and encouraged him or her to ask questions when considering TYSABRI
14. Acknowledgments specific to Multiple Sclerosis (MS)
15. I understand that TYSABRI is indicated as monotherapy for relapsing forms of MS. I understand that this patient has a relapsing form of MS based on clinical and radiological evidence
16. I understand that because TYSABRI increases the risk of PML, it is generally recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate MS therapy. I have discussed other MS treatments with this patient
17. I understand that TYSABRI is not ordinarily recommended for patients who are receiving chronic immunosuppressant or immunomodulatory therapy, or who are significantly immunocompromised from any other cause
18. I understand that an MRI should be performed prior to initiating therapy with TYSABRI in MS patients
19. Acknowledgments specific to Crohn's Disease (CD)
20. I understand that TYSABRI is indicated for adult patients with moderately to severely active CD with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-a
21. I understand that patients receiving TYSABRI should not take concomitant immunosuppressants (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or inhibitors of TNF-a
22. I understand that this patient has moderately to severely active CD with evidence of

inflammation

23. I have discussed other Crohn's disease treatments with this patient
24. I understand that TYSABRI should be discontinued if a patient has not experienced a therapeutic benefit by 12 weeks of therapy
25. I understand that patients receiving steroid therapy at the time of TYSABRI initiation must undergo a steroid tapering regimen once a therapeutic response is achieved. If the patient with Crohn's disease cannot be tapered off of steroids within six months of starting TYSABRI, TYSABRI should be discontinued

## **Versacloz**

1. The healthcare provider enrollment process comprises the following steps that must be completed prior to prescribing Versacloz:
  1. Review the Versacloz package insert and understand the risk of death associated with agranulocytosis or severe granulocytopenia/leukopenia when prescribing Versacloz.
  2. Enroll all applicable patients in the Versacloz Patient Registry. When enrolling a patient, healthcare providers will be matched with an enrolled pharmacy and be defined as an "affiliated treatment pair" by completing the appropriate section of the Patient Enrollment Form.
  3. Understand the recommendations for prescribing and monitoring as described in the Versacloz package insert.
  4. Understand Versacloz should only be prescribed to new patients after verifying an acceptable baseline WBC count ( $\geq 3500/\text{mm}^3$ ) and ANC ( $\geq 2000/\text{mm}^3$ ) test results, submitting the Patient Registration Form with baseline labs within 7 days of blood draw and only after receiving a Patient Registration Number (PRN) from the Versacloz Patient Registry.
  5. Understand that no more than a 7 day supply of Versacloz should be prescribed to a patient who has been continually on clozapine treatment with a different clozapine formulation (i.e. clozapine tablets, clozapine orally disintegrating tablets) prior to initiating Versacloz but who is not currently enrolled in the Versacloz Patient Registry, and understand that Versacloz should not be prescribed in such circumstances until verification that the patient has an acceptable baseline WBC count ( $\geq 3500/\text{mm}^3$ ) and ANC ( $\geq 2000/\text{mm}^3$ ). They understand they should prescribe Versacloz to a patient a second time only after receiving a valid PRN from the Versacloz Patient Registry
  6. Complete the Patient WBC Count and ANC Monitoring Form and provide the affiliated pharmacist with the completed form and a valid prescription for each dispensation of Versacloz.
  7. Follow the process for a patient discontinued from Versacloz, regardless of the reason for discontinuation:
    1. Indicate discontinuation of Versacloz on the Patient WBC Count and ANC Monitoring Form
    2. Notify the Versacloz Patient Registry by submitting the completed Patient WBC Count and ANC Monitoring Form to the Versacloz Patient Registry.
    3. Notify the affiliated pharmacy by submitting the completed Patient WBC Count and ANC Monitoring Form to the affiliated pharmacy
    4. Submit the required WBC count and ANC test results to the Versacloz Patient Registry weekly for at least 4 weeks from the day of discontinuation or until the patients labs return to normal ( $\text{WBC} > 3500/\text{mm}^3$  and  $\text{ANC} > 2000/\text{mm}^3$ ).
  8. Understand the list of patients enrolled in the Versacloz Patient Registry will be used to verify the patient's rechallenge status against the Clozapine National Non-Rechallenge Masterfile.

Furthermore, any patient permanently discontinued from Versacloz for meeting the non-rechallenge criteria (WBC count <2000/mm<sup>3</sup> and/or ANC <1000mm<sup>3</sup>) will be reported to the Clozapine National Non-Rechallenge Masterfile.

9. Understand the Versacloz Patient Registry will be audited to monitor adherence to prescribing and monitoring requirements, and enrolled healthcare providers and pharmacies will be promptly notified of any discrepancies or missing information by Douglas Pharmaceuticals America LTD.

## **Zyprexa Relprevv**

1. Lilly will ensure that, to become certified, prescribers attest to their understanding of the Zyprexa Relprevv Patient Care Program requirements and the risks associated with Zyprexa Relprevv, have completed the mandatory Zyprexa Relprevv training, and have attested that they:
  1. understand the clinical presentation of post-injection delirium/sedation syndrome (PDSS) and how to manage patients should an event occur while using Zyprexa Relprevv;
  2. understand that Zyprexa Relprevv should only be initiated in patients for whom tolerability with oral olanzapine has been established;
  3. understand that Zyprexa Relprevv should only be administered to patients in health care settings (e.g. , hospitals, clinics) that have ready access to emergency response services and that can allow for continuous patient monitoring for at least 3 hours post-injection;
  4. will enroll all patients in the Zyprexa Relprevv Patient Care Program Registry prior to prescribing Zyprexa Relprevv by completing the Patient Registration Form;
  5. will review the Zyprexa Relprevv Medication Guide with each patient or the patient's legal guardian prior to prescribing; and,
  6. understand that the Zyprexa Relprevv Patient Care Program coordinating center may contact the prescriber to resolve discrepancies, to obtain information about a patient, or to conduct occasional surveys.