

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 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. 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.
- 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[®] 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 (* If preferred method)

Phone Type*

Office Mobile Home

Email (* If preferred method)

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)