SILIQ Solutions™

Prescription Information and Enrollment Form

Complete and fax this form to 877-204-3888
For assistance, call 855-RX-SILIQ (855-797-4547), Monday-Friday, 8:00 AM-8:00 PM E.T.

SILIQ™ *(brodalumab) injection 210 mg/1.5 mL*

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____

DOB (MM/DD/YYYY) _____ SSN _____ SEX ☐ M ☐ F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ E-MAIL _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION (REQUIRED)

☐ ENLARGED COPY OF PRESCRIPTION CARD(S) ATTACHED ☐ NO INSURANCE

PRESCRIPTION INSURER _____ PHONE _____

BIN # _____ MEMBER ID # _____

PRIMARY INSURANCE _____

CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____ MEMBER ID # _____

3. PATIENT AUTHORIZATION

Patient should read the Patient Authorization on page 3 and sign where indicated.
Patient signature on page 3 confirms the patient has read, understands and agrees to the Patient Authorization to release their Protected Health Information to Valeant North America LLC, its agents and contractors, as described in the Patient Authorization on page 3.

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____ OFFICE CONTACT _____

PRACTICE NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____

STATE LICENSE # _____ UPIN/NPI # _____

Before prescribing SILIQ, please see Boxed Warning about suicidal ideation and behavior on reverse.

5. TREATMENT INFORMATION (REQUIRED)

SILIQ—DIAGNOSIS: Plaque Psoriasis (L40.0) DATE OF DIAGNOSIS _____ BSA AFFECTED % _____

TB TEST DATE _____ RESULT _____ HEP C PANEL DATE _____ RESULT _____

6. PREVIOUS TREATMENTS TRIED AND FAILED (Check all that apply or attach list of "tried and failed" therapies)

☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Methotrexate ☐ Otezla

☐ Remicade ☐ Stelara ☐ Taltz ☐ Other systemic therapy _____

☐ Other _____ ☐ Phototherapy

7. PREFERRED QUALIFIED PHARMACY

Pharmacies must be certified under the SILIQ REMS Program. A list of qualified pharmacies is available at SILIQREMS.com or by calling Siliq Solutions™ at 855-RX-SILIQ (855-797-4547). As the treating physician, I have discussed preference for a qualified pharmacy with this patient, who prefers use of the qualified pharmacy indicated below. I authorize Valeant Pharmaceuticals and its representatives to fax this prescription to: the qualified pharmacy designated below, provided it is approved by the patient's plan; to a qualified pharmacy approved by this patient's plan if the qualified pharmacy designated is not a plan-approved pharmacy; to any qualified pharmacy approved by this patient's plan if no qualified pharmacy is indicated.

PHARMACY _____ PHONE _____ FAX _____

8. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. Prescription only valid if received by fax. If not faxed, prescription must be submitted on state-specific form, if required for your state)

Rx: SILIQ™ (brodalumab) injection, for subcutaneous use

INDUCTION DOSE: ☐ 210-mg subcutaneous injection at Weeks 0, 1, and 2 Requested Ship Date _____

MAINTENANCE DOSE: ☐ 210-mg subcutaneous injection every 2 weeks Requested Ship Date _____

Quantity to be Dispensed: ☐ 1 month ☐ 2 months ☐ 3 months Refills # _____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION (NO STAMPS ALLOWED): I certify that I made the prescribing decisions indicated above based on my own independent medical judgment regarding what is in the best interest of the patient and that I have reviewed the current SILIQ Prescribing Information. By signing below, I confirm that: (1) I am certified as a healthcare provider under the SILIQ REMS Program, (2) I have counseled the patient on the risks of suicidal ideation and behavior that may occur with SILIQ, (3) the patient has signed the SILIQ REMS Patient-Prescriber Agreement, (4) I have given the patient the SILIQ REMS patient wallet card, and (5) I have enrolled the patient in the SILIQ REMS Program. I authorize Siliq Solutions to act on my behalf to transmit this prescription to the appropriate qualified pharmacy designated above by the patient or the patient's plan.

SIGNATURE ▶ _____

☐ Dispense as Written Date

SIGNATURE ▶ _____

☐ Substitution Allowed Date

9. SHIPPING INFORMATION FOR SILIQ (Not required if same as Patient Information)

SHIP TO: ☐ Provider's Office ☐ Patient's Home ☐ First Delivery to Provider's Office; Subsequent Deliveries to Patient's Home

NAME (if different than patient) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

Copy for the Patient

Instructions to the Provider

1. **The patient should read this form and sign to receive Siliq Solutions™ services.**
2. **Fax page 1 and this signed form to 877-204-3888.**
3. **Give the patient a copy of page 1 and this sheet which they have signed.**

PATIENT AUTHORIZATION

By signing this Patient Authorization Form, I confirm that I authorize my healthcare providers, pharmacies and health plans to disclose my Protected Health Information ("PHI") related to the Siliq Solutions services such as my demographic information (e.g., name, address, phone number, health insurance), diagnosis, medical condition, treatment and prescription information (e.g., dose, prior medications) to Valeant North America LLC and its agents and contractors ("Valeant"), and for Valeant to receive, use and disclose my PHI, to: 1) establish my eligibility for benefits through Siliq Solutions; 2) communicate with my healthcare providers, health plans and me about my medical care as it relates to SILIQ™ (brodalumab) injection, for subcutaneous use; 3) provide reimbursement and product support services including facilitating the provision of SILIQ to me; 4) contact me directly by phone, mail, or email, about and enroll me in, Siliq Solutions support services; 5) investigate, verify, assist with, and coordinate my coverage for SILIQ with my health care providers and health plan; 6) coordinate prescription fulfillment; 7) conduct analyses related to the quality, efficacy, and safety of SILIQ, as well as patient access and adherence to SILIQ; 8) provide my healthcare providers and me with educational materials, information, and services related to SILIQ. I understand that there is some risk that email communications could be intercepted or accessed by third parties, and consent to Valeant communicating with me via email in connection with the Siliq Solutions services. I understand that my PHI will not be used or disclosed by Valeant for any other purpose unless permitted by applicable law or unless my personally identifiable information is removed. I understand that once my PHI has been disclosed to Valeant, federal privacy laws may no longer restrict its further disclosure.

I further understand that I may refuse to sign this Patient Authorization Form. My Healthcare Providers or Insurers will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this Authorization Form. If I do not sign the Patient Authorization Form, or if I revoke this Authorization, I understand that I will not be able to participate in or receive assistance from Siliq Solutions.

I understand that my Pharmacy may receive payment or a fee from Valeant in exchange for disclosing certain information to Valeant pursuant to this Authorization. This Authorization will continue in effect until Valeant is no longer providing me with Siliq Solutions services or otherwise as required by state law. I have the right to revoke this Authorization at any time by calling Siliq Solutions at 855-RX-SILIQ (855-797-4547) or by contacting my healthcare provider(s) or health plans, sending a letter to Siliq Solutions at P.O. Box 220761, Charlotte, NC, 28222 or sending a fax to Siliq Solutions at 877-204-3888. If I revoke this Authorization, I understand that I will no longer be able to participate in the Siliq Solutions program. In addition, the revocation will prohibit further disclosures of my PHI to Valeant, but will not affect previous uses or disclosures of my PHI made in reliance on this Authorization. If the support services for SILIQ are discontinued, I understand that this Authorization will also end.

My signature below confirms I have read, understand and agree to the Patient Authorization to release my Protected Health Information to Valeant North America LLC, its agents and contractors, as described in the Patient Authorization.

Signature of Patient/Personal Representative Date

Print Name of Patient Personal Representative Relationship to Patient (If Applicable)

You are encouraged to report negative side effects of prescription drugs to FDA at www.fda.gov/MedWatch, or call 1-800-FDA-1088.

IMPORTANT SAFETY INFORMATION

Suicidal thoughts or behavior: Some patients taking SILIQ have had suicidal thoughts or ended their own lives. This risk is higher if you have a history of suicidal thoughts or depression. It is not known if SILIQ causes these thoughts or actions. Get medical help right away if you or a family member notices that you have any of the following symptoms:

- new or worsening depression, anxiety, or mood problems
- thoughts of suicide, dying, or hurting yourself
- attempt to commit suicide, or acting on dangerous impulses
- other unusual changes in your behavior or mood

Your healthcare provider will give you a SILIQ patient/wallet card about symptoms that need medical attention right away. Carry the card with you during treatment with SILIQ and show it to all of your healthcare providers.

Before taking SILIQ, please see Important Safety Information about the risk of suicide, above. For full Prescribing Information and Medication Guide, visit SILIQ.com or call Valeant Medical Information at (877) 361-2719 to request that it be faxed, emailed or mailed to you instead.

VALEANT® Dermatology

INDICATION

SILIQ™ (brodalumab) injection, for subcutaneous use, is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies.

IMPORTANT SAFETY INFORMATION

WARNING: SUICIDAL IDEATION AND BEHAVIOR

Suicidal ideation and behavior, including completed suicides, have occurred in patients treated with SILIQ. Prior to prescribing SILIQ, weigh the potential risks and benefits in patients with a history of depression and/or suicidal ideation or behavior. Patients with new or worsening suicidal ideation and behavior should be referred to a mental health professional, as appropriate. Advise patients and caregivers to seek medical attention for manifestations of suicidal ideation or behavior, new onset or worsening depression, anxiety, or other mood changes [see Warnings and Precautions in the full Prescribing Information].

Because of the observed suicidal behavior in subjects treated with SILIQ, SILIQ is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the SILIQ REMS Program [see Warnings and Precautions in the full Prescribing Information].

Crohn's Disease SILIQ is contraindicated in patients with Crohn's disease. In clinical trials, which excluded Crohn's patients, one SILIQ-treated patient was withdrawn after developing Crohn's disease.

SILIQ Risk Evaluation and Mitigation Strategy (REMS) Program SILIQ is available only through a restricted program called the SILIQ REMS because of observed suicidal ideation and behavior in patients treated with SILIQ. Before prescribing SILIQ, prescribers must be certified with the program, have each patient sign a Patient-Prescriber Agreement Form, and provide the patient a Wallet Card describing symptoms requiring immediate medical evaluation. Pharmacies must be certified and only dispense to patients authorized to receive SILIQ. More information is available at SILIQREMS.com.

Infections SILIQ may increase the risk of infections. Serious infections and fungal infections were observed at a higher rate in patients treated with SILIQ than placebo-treated patients in clinical trials, including one case of cryptococcal meningitis that led to discontinuation of therapy.

- Consider risks and benefits prior to prescribing SILIQ in patients with a chronic infection or history of recurrent infection
- Instruct patients to seek treatment if signs or symptoms of a chronic or acute infection occur

Risk for Latent Tuberculosis (TB) Reactivation Evaluate patients for TB prior to initiating treatment with SILIQ and do not treat patients with active TB. Initiate treatment for latent TB prior to starting SILIQ and consider anti-TB therapy prior to initiation in patients with history of latent TB if adequate treatment cannot be confirmed. Monitor closely for symptoms of active TB during and after treatment.

Immunizations Avoid use of live vaccines in patients treated with SILIQ.

Adverse Reactions The most commonly reported adverse reactions in clinical trials were arthralgia, headache, fatigue, diarrhea, oropharyngeal pain, nausea, myalgia, injection site reactions, influenza, neutropenia, and tinea infections.

To report SUSPECTED ADVERSE REACTIONS, contact Valeant Pharmaceuticals at 1-800-321-4576 or FDA at 1-800-FDA-1088, or visit www.fda.gov/MedWatch.

By providing your information and information about your patient on the front of the Prescription Information and Enrollment Form, you are requesting the services described on this form. The information you provide will only be used by Valeant Pharmaceuticals, our affiliates, and our service providers, including Siliq Solutions™, involved in delivering these services. You may withdraw your request for these services by calling 855-RX-SILIQ (855-797-4547). Our Privacy Policy, available at Valeant.com/privacy, governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Disclaimer

Patient insurance benefit investigation is performed by The Lash Group, Inc., under contract for Valeant Pharmaceuticals. The Lash Group, Inc., provides assistance in determining if treatment may be covered by the payer based on the payer's health plan guidelines and the patient information provided by you as authorized by the patient after your determination of medical necessity.

Verification of insurance coverage is the responsibility of the provider. Reimbursement by payers is subject to many factors. The Lash Group, Inc. and Valeant Pharmaceuticals do not represent or guarantee that payer reimbursement or other payment will be made. The information provided as a result of the benefit investigation is provided for your information only. Although The Lash Group, Inc. makes every effort to be accurate in the information provided, no representations or warranties are expressed or implied by The Lash Group, Inc. and Valeant Pharmaceuticals regarding the accuracy of the information. The Lash Group, Inc. and Valeant Pharmaceuticals, and their respective agents or employees, shall not be liable for any costs or damages as a result of or related to patient support. Providers and additional users of this information accept responsibility for their use of the information.

Valeant Pharmaceuticals does not assume responsibility for, nor guarantee the availability, scope, or quality of the patient support services offered including reimbursement support, prescription fulfillment coordination, and other services. Providers are responsible for the services they provide, not Valeant Pharmaceuticals. The patient support services are included within the cost of the product and have no value apart from the product.

For full Prescribing Information, click here or see accompanying full Prescribing Information, including Boxed Warning about suicidal ideation and behavior.

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