TURALIO™ REMS

Pharmacy Enrollment Form

To become certified in the TURALIO REMS and dispense TURALIO, a pharmacy must designate an Authorized Representative to:

1. Review the **Program Overview**
2. Complete and submit this **Pharmacy Enrollment Form**
3. Oversee implementation and compliance of the TURALIO REMS requirements

Submit the completed Pharmacy Enrollment Form via:

a. Fax to the TURALIO REMS at 1-833-TRL-REMS (833-875-7367), or

b. E-mail to Enroll@TURALIOREMS.com

Authorized Representative Attestations

As the Authorized Pharmacy Representative, I attest that:

- I have reviewed the **Program Overview**.
- I must complete the **Pharmacy Enrollment Form** and submit it to the TURALIO REMS.
- I agree to train all relevant staff involved in dispensing TURALIO using the **Program Overview**.

Before dispensing I will ensure that all pharmacy staff must:

- Obtain authorization to dispense each prescription by contacting the TURALIO REMS to verify the prescriber is certified, and the patient is enrolled and authorized to receive TURALIO.
- Dispense no more than a 30 days supply for each of the first 3 months of treatment.

On behalf of the pharmacy, we will comply with the following TURALIO REMS requirements:

- Report adverse events of serious and potentially fatal liver injury by submitting the **Liver Adverse Event Reporting Form**.
- Not distribute, transfer, loan or sell TURALIO, except to certified dispensers.
- Maintain records documenting staff's completion of training.
- Maintain records that all TURALIO REMS processes and procedures are in place and being followed.
- Maintain and submit dispensing information for all patients.
- Comply with audits carried out by Daiichi Sankyo, Inc. or third party acting on behalf of Daiichi Sankyo, Inc. to ensure that all processes and procedures are in place and are being followed.

Authorized Representative: Please PRINT your name and phone number here.

*Name: _____ _____ *Phone Number:_____ Last First	
*Authorized Representative Signature:	*Date:

Authorized Representative Information **Note: Fields marked with an * are REQUIRED.**		
*First Name:	*Last Name:	Middle Initial:
*Title/Position:		
*Telephone Number:	*Fax Number:	
*E-mail:		
*Preferred Method of Communication (please select one): ☐ Fax ☐ E-mail ☐ Phone		

Pharmacy Information		
Pharmacy Name:		
*Pharmacy Street Address:		
*City:	*State:	*ZIP Code:
*Pharmacy Phone Number:	*Pharmacy Fax Number:	
*Pharmacy National Provider Identifier (NPI) #:		

☐ **If you are certifying more than one pharmacy location, check this box and provide the information on the following page for each site. Use as many forms as necessary.**

By completing and submitting this form as directed above and receiving certification confirmation, your pharmacy will be certified in the TURALIO REMS. You will receive confirmation of your certification via e-mail.

Authorized Representative: Please PRINT your name and phone number here.

*Name: _____ _____ *Phone Number:_____
Last First

CERTIFYING MULTIPLE LOCATIONS

If you are certifying more than one pharmacy location, the following information will need to be provided for each site. Use additional forms as necessary.

Pharmacy Information **Note: Fields marked with an * are REQUIRED.**		
Pharmacy Name:		
*Pharmacy Address:		
*City:	*State:	*ZIP Code:
*Pharmacy Phone Number: Area Code/Telephone Number	*Pharmacy Fax Number:	
*Pharmacy National Provider Identifier (NPI) #:		
Pharmacy Name:		
*Pharmacy Address:		
*City:	*State:	*ZIP Code:
*Pharmacy Phone Number: Area Code/Telephone Number	*Pharmacy Fax Number:	
*Pharmacy National Provider Identifier (NPI) #:		

Authorized Representative: Please PRINT your name and phone number here.

*Name: _____ _____ *Phone Number:_____
Last First