Bosentan
REMS Program

Inpatient Pharmacy Enrollment Form

Phone: 1-866-359-2612
Fax: 1-800-730-8231

Instructions

For immediate enrollment, please go to www.BosentanREMSProgram.com.

To submit this form via fax or mail, please complete all required fields below and fax to 1-800-730-8231 or mail to the Bosentan REMS Program, P.O. Box 29080, Phoenix, AZ 85038. You will receive a confirmation via the contact preference you list below.

If you have questions, require additional information, or need additional copies of Bosentan REMS Program documents, please visit the program website at **www.BosentanREMSProgram.com**, or call the Bosentan REMS Program at 1-866-359-2612.

Authorized Representative Responsibilities

I am the authorized representative designated by my pharmacy to oversee implementation of and compliance with the Bosentan REMS Program. I attest to understanding the Bosentan REMS Program requirements, and accept responsibility to:

1. Complete and sign this ***Bosentan REMS Program Inpatient Pharmacy Enrollment Form*** on behalf of the pharmacy, and submit the form to the Bosentan REMS Program
2. Review the Bosentan REMS Program Pharmacy Guide
3. Ensure all relevant staff involved in the dispensing of bosentan are trained on the Bosentan REMS Program requirements as described in the ***Bosentan REMS Program Pharmacy Guide*** and maintain a record of the training
4. Recertify in the Bosentan REMS Program if the pharmacy designates a new authorized representative
5. Report all adverse events including those suggestive of hepatotoxicity to the Bosentan REMS Program
6. Report any pregnancy and all available information during treatment with bosentan to the Bosentan REMS Program
7. Maintain documentation that all processes and procedures are in place and are being followed for the Bosentan REMS Program and provide upon request to the Bosentan Sponsors or a third party acting on behalf of the Bosentan Sponsors
8. Comply with audits by the Bosentan Sponsors or a third party acting on behalf of the Bosentan Sponsors to ensure that all processes and procedures are in place and are being followed for the Bosentan REMS Program
9. Put processes and procedures in place to ensure the following requirements are completed prior to dispensing bosentan:
    a. Verify the patient is under the supervision and care of a prescriber who is certified
    b. Verify the patient is enrolled or will be enrolled prior to discharge
    c. Dispense no more than a 15-day supply of bosentan upon discharge
10. Verify the requirements by the following mechanisms, including but not limited to calling the Bosentan REMS Program Contact Center, accessing the ***Bosentan REMS Program Website***, or by accessing the patient's medical records
11. Not transfer bosentan to any pharmacy, practitioner, or any healthcare setting not certified in the Bosentan REMS Program

Pharmacy Information (All fields required)

Pharmacy Name:

Provide one of the following identifiers: NCPDP: NPI: DEA:

Address: City:

State: Zip:

Phone: Fax:

Authorized Representative Information (All fields required)

First Name: Last Name:

Credentials: ❒ R.Ph ❒ PharmD ❒ BCPS ❒ Other

Phone: Fax: Email Address:

Preferred method of contact: ❒ Fax ❒ Email

Authorized Representative Signature

By signing below, you signify your understanding of the risks of bosentan treatment, your obligations as a pharmacy certified in the Bosentan REMS Program as outlined above, and you agree to oversee the implementation of and compliance with the Bosentan REMS Program requirements for this pharmacy.

Signature: **Date:**