Bosentan
REMS Program

Patient Enrollment Form

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

Instructions

For immediate patient enrollment, please go to www.BosentanREMSProgram.com. The patient must complete this form with the prescriber. The form may be completed using this paper copy or online.

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.

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.

Patient Agreement and Signature

To become enrolled in the Bosentan REMS Program, a patient and/or parent/legal guardian is indicating that he/she has:

1. Received and has read the ***Bosentan REMS Program Guide for Patients***
2. Received counseling from the healthcare professional regarding:
   a. the risk of liver damage, the signs and symptoms of liver damage and, as appropriate, the risk of serious birth defects, and the need to use reliable contraception
   b. the need to complete liver function testing and, as appropriate, pregnancy testing, as outlined in the ***Bosentan REMS Program Guide for Patients***
   c. the Bosentan REMS Program contacting you prior to each dispense of bosentan to confirm that liver function tests and, as appropriate, pregnancy test were completed and provide counseling
3. Completed and signed this ***Bosentan REMS Program Patient Enrollment Form*** with the healthcare professional

Patient Information (All fields required unless otherwise indicated)

First Name:	MI (opt):	Last Name:	Gender:
Date of Birth (MM/DD/YYYY):		Email Address (opt):	
Primary Phone #:		Alternate Phone # (opt):	
Address:		City:	
State:		Zip:	
Legal Guardian (opt):		Relationship (opt):	

By signing below, you attest that you understand the requirements of the Bosentan REMS Program as indicated on this form and in the ***Bosentan REMS Program Guide for Patients***, and you will follow the requirements of the Bosentan REMS Program.

Patient/Parent/Legal Guardian Signature: **Date:**

Patient Reproductive Classification and Acknowledgement of Counseling (To be completed by the prescriber)

For this patient, have you reviewed their current liver function tests? ❒ Yes ❒ No

If your patient is FEMALE, select the correct female patient category (please see definitions of these terms in the *Bosentan REMS Program Prescriber Guide*):

❒ Female of Reproductive Potential

If this patient is a female of reproductive potential, has a negative pregnancy test been completed prior to prescribing bosentan?
❒ Yes ❒ No

❒ Female of Non-Reproductive Potential

Please specify:
❒ Pre-pubertal Female ❒ Post-menopausal Female
❒ Female with other medical reasons for permanent, irreversible infertility

For this patient, have you provided counseling on the risks associated with bosentan treatment and the Bosentan REMS Program requirements? ❒ Yes ❒ No

Prescriber Information (All fields required unless otherwise indicated)

First Name:	MI (opt):	Last Name:	
NPI# or DEA#:			
Address:		City:	
State:		Zip:	
Phone:	Ext (opt):	Fax:	

Prescriber Signature

By signing below, you attest that the patient indicated on this form meets the reproductive potential classification as defined in the ***Bosentan REMS Program Prescriber Guide,*** and that you agree to follow the requirements of the Bosentan REMS Program.

Prescriber Signature: **Date:**