



PREScriBER ENROLLMENT AND AGREEMENT FORM

For real-time processing of this form, go to www.vigabatrinREMS.com to enroll online. To submit form via fax, please complete all required fields below and fax both pages to the Vigabatrin REMS at 1-866-205-3072. You will receive confirmation of your certification via e-mail.

Please call 1-866-244-8175 with any questions regarding the REMS and initiating treatment with vigabatrin.

By completing, signing, and submitting this form, I acknowledge that I have reviewed the Prescribing Information for vigabatrin, and I agree to be enrolled in the Vigabatrin REMS.

As a condition of certification:

- I will enroll each patient in the Vigabatrin REMS by:
 - Counseling the patients/parents/legal guardians considering treatment on the benefits and risks of vigabatrin, including permanent vision loss and the need for periodic monitoring of vision, and providing them with a copy of the **Patient Guide**
 - Completing the **Patient/Parent/Legal Guardian–Physician Agreement Form** for each patient and providing a completed copy to the patient/parent/legal guardian. I will submit the completed form to the REMS and store a copy in the patient's records
- Ensuring that periodic monitoring of vision, as described in the Prescribing Information, is performed on an ongoing basis for each patient
- Reporting any adverse event suggestive of vision loss to the REMS with all available information

I understand that if I do not maintain compliance with the requirements of the Vigabatrin REMS, I will no longer be able to prescribe vigabatrin

Prior to dispensing vigabatrin, the REMS will provide a confirmation of certification to the e-mail address listed on page 2.

For additional information, visit www.vigabatrinREMS.com or call the Vigabatrin REMS at 1-866-244-8175.

Form continues on page 2.

*Prescriber NPI# _____



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Form continued from page 1.

Note: Fields marked with an * are REQUIRED.

*First Name _____ Middle Initial _____ * Last Name _____

*Prescriber NPI# _____

Institution Name (if applicable) _____

*Prescriber Address _____
Street City State ZIP Code

*Telephone Number _____ Alternative Telephone Number _____
Area Code/Telephone Number Area Code/Telephone Number

*Office Fax Number _____
Area Code/Fax Number

*Email _____

Prescriber Degree ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other

Specialty ☐ Epileptology ☐ Neurology ☐ Pediatric Neurology ☐ Internal Medicine ☐ Other

Office Contact Name _____
First Last Area Code/Telephone Number

Second Contact Name _____
First Last Area Code/Telephone Number

*Prescriber Signature _____ *Date _____
Month/Day/Year

By completing, signing, and submitting this form and receiving certification confirmation by e-mail, you will be certified in the Vigabatrin REMS and may begin prescribing vigabatrin. You only need to enroll and complete the certification in the program once, and you are under no obligation to prescribe vigabatrin.

To report Adverse Events, please contact the REMS at 1-866-244-8175