HOSPITAL PHARMACY'S ACCEPTANCE OF RESPONSIBILITIES

Plenaxis™ PLUS Program

For safety reasons, the marketing of Plenaxis™ is restricted. The Plenaxis™ **PLUS** Program (Plenaxis™ User Safety Program) ensures hospital pharmacies understand that only physicians who are enrolled with PRAECIS PHARMACEUTICALS INCORPORATED and are listed in the Plenaxis™ Prescriber's Registry should prescribe Plenaxis™. Hospital pharmacies must accept the responsibilities below to receive Plenaxis™ from PRAECIS PHARMACEUTICALS INCORPORATED or its distributors.

- I understand that because of the risk of immediate-onset systemic allergic reactions, including hypotension and syncope, and because of the risk of loss of effectiveness over time, Plenaxis™ is only indicated for the palliative treatment of men with advanced symptomatic prostate cancer, in whom LHRH agonist therapy is not appropriate and who refuse surgical castration, and have one or more of the following: (1) risk of neurological compromise due to metastases, (2) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or (3) severe bone pain from skeletal metastases persisting on narcotic analgesia.

- Hospital pharmacists will:
  - Verify that each prescriber has been confirmed in the Plenaxis™ Prescribers' Registry before dispensing Plenaxis™. Confirmation of registry participants can be accomplished via the interactive voice response (IVR) telephone number, 1-866-PLENAXIS (1-866-753-6294).
  - Dispense all doses of Plenaxis™ with Patient Information.

I understand that I may withdraw my enrollment in the Plenaxis™ **PLUS** Program by a written statement submitted to PRAECIS PHARMACEUTICALS INCORPORATED (contact information below) or that PRAECIS PHARMACEUTICAS INCORPORATED may withdraw this pharmacy from the Plenaxis™ **PLUS** Program if they do not meet the agreed upon responsibilities.

By signing below, I acknowledge and accept the above responsibilities.

Print Name _____ Signature _____

Title _____ Date _____

Hospital Pharmacy License #_____

Hospital Pharmacy Name _____

Shipping Address _____

City _____ State/Zip _____

Billing Address _____

City _____ State/Zip _____

Phone _____ Fax _____

E-mail _____

You may also complete this form online by visting www.plenaxisplus.com

Fax completed and signed form to: **PRAECIS PHARMACEUTICALS INCORPORATED**

Attention: Plenaxis™ **PLUS** Program
c/o SENTRX
Overlook at Great Notch
150 Clove Road
Little Falls, New Jersey 07424
Fax Number: 1-800-648-8180

Request additional materials
Package Inserts
Patient Information
Physician Attestations

09-01