FORM A – PHARMACY STOCKING FORM

Mylan™
CLOZAPINE
Tablets, USP

CLOZAPINE *Prescription Access System*™

P.O. Box 4649, Star City, WV 26504-4649 • Toll-free Phone: 800-843-9915 • Toll-free Fax: 800-843-9916
Website: www.mylan-clozapine.com

A. I am completely familiar with the Clozapine Prescribing Information, including BOXED WARNINGS concerning the risk associated with clozapine use: 1) potentially life-threatening agranulocytosis and granulocytopenia; 2) seizures; 3) fatal myocarditis; 4) orthostatic hypotension, with or without syncope, accompanied by rare cases of respiratory and/or cardiac arrest; and 5) increased mortality in elderly patients with dementia-related psychosis.

B. I understand that each of my patients must be enrolled in the CLOZAPINE *Prescription Access System* (CPAS) to reduce the potential of rechallenging patients at risk. Clozapine should not be prescribed before receiving a patient reclearance from CPAS. I agree to report all White Blood Cell (WBC) counts and Absolute Neutrophil Count (ANC) values (normal and abnormal) to CPAS. Reports will be sent within 7 days of collection for patients who are monitored weekly, within 14 days of collection for patients who are monitored every 2 weeks, and within 28 days for patients who are monitored every 4 weeks.

C. I understand that CPAS strongly recommends my enrollment in a local quality assurance committee to help ensure compliance with the Clozapine Prescribing Information requirements. CPAS will notify the physician and pharmacist of all issues regarding noncompliance.

D. I agree to register the patient and access group prior to dispensing the next week's supply of *Mylan* Clozapine.

The completion of this document demonstrates my intention and the intention of all dispensing pharmacists in this pharmacy to participate in CPAS. I/we have devised a plan for a clozapine access group that meets the requirements of the Prescribing Information. Signing this form constitutes commitment on my/our part to ensure drug dispensing will be contingent upon receipt of WBC count and ANC monitoring test results and will be performed in compliance with the guidelines of CPAS.

_____ / / _____
Pharmacist's Signature Date M D Y

PHARMACIST (If registered with CPAS, only DEA/ID number is required.)

Pharmacy DEA/ID Number

Pharmacist's Name (Type or Print) & Title

Pharmacy Name

Address City State Zip Code

( ) Phone Number

( ) Fax Number

Wholesaler

( ) Phone Number

City State

( ) Fax Number

Please respond to the following questions by placing an "x" in the appropriate box:

- Is clozapine (branded or generic) currently dispensed from your pharmacy? ☐ YES ☐ NO
- Is your pharmacy registered with a clozapine monitoring program? ☐ YES ☐ NO

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