FORM B – PHYSICIAN, PHARMACY, AND PATIENT REGISTRATION 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 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 the pharmacy for submission 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. Finally, I agree to notify CPAS promptly of all discontinued patients and submit the results weekly for at least 4 weeks from day of discontinuation or until WBC count $\geq$3500/mm^3 and ANC $\geq$2000/mm^3.

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.

The completion of this document demonstrates my intention to participate in CPAS. I have devised a plan for a clozapine access group that meets the requirements of the Prescribing Information. Signing this form constitutes commitment on my 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.

Physician's Signature _____ Date ___/___/___ (M D Y)

Pharmacist's Signature _____ Date ___/___/___ (M D Y)

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

Physician's Name (Type or Print) & Title _____ Physician's DEA/NPI/ID Number ☐☐ ☐☐☐☐☐☐☐☐☐

Address _____ City _____ State _____ Zip Code _____

Phone Number ( ) _____ Fax Number ( ) _____

Associated Institution (Include Address) _____

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

Pharmacist's Name (Type or Print) & Title _____ Pharmacy DEA/NPI/ID Number ☐☐ ☐☐☐☐☐☐☐☐☐

Pharmacy Name _____

Address _____ City _____ State _____ Zip Code _____

Phone Number ( ) _____ Fax Number ( ) _____

Wholesaler _____ Phone Number ( ) _____

City _____ State _____ Fax Number ( ) _____

PATIENT

Initials ☐☐ (First Last) Date of Birth ☐☐ (M) ☐☐ (D) ☐☐☐☐ (Y) Sex ☐ (M/F) ☐☐☐☐☐ Zip Code

Race ☐ W ☐ Afr/A ☐ Hisp ☐ Asian ☐ Other ☐☐☐-☐☐-☐☐☐☐ Patient's Social Security #

☐ New patient? OR ☐ Patient with interrupted treatment?

Patient continuing treatment? Y ☐ N ☐

If continuing treatment? ☐ Weekly ☐ Every 2 weeks ☐ Every 4 weeks

How many weeks of continuous therapy and WBC $\geq$3500/mm^3 and ANC $\geq$2000/mm^3? ___ OR Most recent clozapine start date and continuous therapy and WBC $\geq$3500/mm^3 and ANC $\geq$2000/mm^3. ___ (M/D/Y)

Completed by the *Clozapine Prescription Access System* Reclearance Code ☐☐☐☐☐☐☐ Confirmed by _____ Date _____

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White: CPAS Yellow: Pharmacy Pink: Physician

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