FORM C – WBC COUNT AND ANC REPORTING FORM

Mylan™
CLOZAPINE
Tablets, USP

CLOZAPINE *Prescription Access System*™

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The completion of this document demonstrates my intention to participate in the CLOZAPINE *Prescription Access System* (CPAS) and to participate in a plan that ensures that drug dispensing will be contingent upon receipt of White Blood Cell (WBC) count and Absolute Neutrophil Count (ANC) test results that are within normal limits and timeframe according to the guidelines outlined in the Clozapine Prescribing Information. Completion of this form constitutes a continuing commitment to adhere to the guidelines outlined in the Clozapine Prescribing Information and the parameters of CPAS.

PATIENT

First Last Initials ☐☐

Patient's Reclearance Code ☐☐☐☐☐☐☐

Patient's Social Security # ☐☐☐-☐☐-☐☐☐☐

MONITORING FREQUENCY

Please mark appropriate box

☐ WEEKLY ☐ EVERY 2 WEEKS ☐ EVERY 4 WEEKS

Patient's Treatment ☐ Pretreatment ☐ Active ☐ Interrupted ☐ Discontinued

Blood Draw Date ☐☐ M ☐☐ D ☐☐ Y

Total WBC Count (per mm^3) x 10^3 ☐☐.☐ x 10^3

Total ANC (per mm^3) x 10^3 ☐☐.☐ x 10^3

Are WBC Count and ANC Acceptable for Dispensing? ☐ Yes ☐ No

Today's Clozapine Dosage: ☐☐☐ Total mg/Day

Dispensed From: ☐ Bottle ☐ Unit Dose

Date of Dispensing: ☐☐ M ☐☐ D ☐☐ Y

PRESCRIBING REMINDERS:

Initial hematological values should be: WBC counts ≥3500/mm^3 and ANCs ≥2000/mm^3. Monitor weekly for six months.	If subsequent WBC counts are ≥3500/mm^3 and ANCs ≥2000/mm^3 for six to twelve months, monitor every two weeks for six months.	If total WBC counts are ≥3500/mm^3 and ANCs ≥2000/mm^3 for a year, monitor every four weeks indefinitely.	If total WBC count is <3000/mm^3 and ≥2000/mm^3 or ANC <1500/mm^3 and ≥1000/mm^3, therapy should be interrupted and **patient closely monitored.**	Please see full Prescribing Information for instructions regarding reinitiating clozapine therapy.	If total WBC count is <2000/mm^3 or ANC <1000/mm^3, therapy should be discontinued and **patient should never be rechallenged with clozapine.**

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

Registered Physician ☐ Covering Physician ☐

Physician's DEA/NPI/ID Number ☐☐☐☐☐☐☐☐☐☐

Physician's Signature

Registered Physician's Name (Type or Print) & Title

Covering Physician's Name

Address City State Zip Code

( ) Phone Number ( ) Fax Number

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

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White: CPAS Yellow: Pharmacy Pink: Physician

CLZ-LIT-013R2 (MYLCLO007-11/10)