CLOZAPINE REMS

Patient Enrollment Form

Phone: 888-586-0758
Fax: 800-878-5927
www.clozapinerems.com

Instructions for Prescribers and Prescriber Designees

This form may be completed by a certified prescriber or a prescriber designee.

Complete this form for a patient if:

- re-enrolling a patient into the Clozapine REMS
- the patient has never been treated with clozapine previously, or
- you have never treated this patient with clozapine (regardless of the patient's history of clozapine treatment)

A prescriber must complete the form to designate the patient as a Benign Ethnic Neutropenia (BEN) patient or a Hospice Care patient. A prescriber designee may not complete the form for these patients.

For immediate enrollment, please go to www.clozapinerems.com.

For enrollment via fax, please complete all required fields below and fax to 800-878-5927. For enrollment via the Clozapine REMS Contact Center, please call 888-586-0758. Enrollment confirmation will be sent via the contact preference specified on the prescriber's *Clozapine REMS Prescriber Enrollment Form*.

Clozapine is only available through the single shared Clozapine REMS (Risk Evaluation and Mitigation Strategy). In order to treat a patient with clozapine, the patient MUST be enrolled in the Clozapine REMS. To enroll a patient, you must:

1. Inform the patient or caregiver about the risk of severe neutropenia with clozapine and the Clozapine REMS requirements including to report signs of infection
2. Provide the patient or caregiver with *A Guide for Patients and Caregivers: What You Need to Know about Clozapine and Neutropenia* unless you determine that the patient's adherence to the treatment regimen will be negatively impacted by providing the *A Guide for Patients and Caregivers: What You Need to Know about Clozapine and Neutropenia* and informing them about this risk
3. Complete and submit this *Clozapine REMS Patient Enrollment Form*

Patient Information (* Required Field)

First Name*:	Last Name*:
Gender*: ☐ Male ☐ Female ☐ Other	Date of Birth* (MM/DD/YYYY): / /
Race*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____	
Ethnicity*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Phone:	Email Address:
Does the patient have a permanent address*? ☐ Yes ☐ No	Zip Code:

Patient Status (* Required Field)

Is this patient actively on clozapine therapy*? ☐ Yes ☐ No ☐ Unknown

If Yes, what is this patient's current monitoring frequency?

☐ 3 times a week ☐ Every 2 weeks ☐ Weekly ☐ Monthly

Baseline or Most Recent Lab Information (All Fields Required)

Blood Draw Date (MM/DD/YYYY):	ANC (per µL):

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Prescriber Information (* Required Field)

First Name*:	Last Name*:	Individual NPI Number*:
Phone:	Email:	Fax:

Prescriber Designee Information (All Fields Required if Form is Completed by a Prescriber Designee)

First Name*:	Last Name*:	
Phone*:	Fax:	Email:

Benign Ethnic Neutropenia (BEN) Patient Attestation (Prescriber signature required for attestation of BEN diagnosis)

A BEN patient designation provides a separate ANC monitoring algorithm for the patient. The BEN designation is a permanent status.

By signing below, I attest that the above is a patient with documented benign ethnic neutropenia.

Prescriber Signature: _____ **Date (MM/DD/YYYY):** _____

Hospice Care Patient Attestation (Prescriber signature required for attestation of Hospice Care)

For hospice patients (i.e., terminally ill patients with an estimated life expectancy of six months or less), the prescriber may reduce the frequency of submitting a Patient Status Form to once every 6 months after a discussion with the patient and his/her caregiver. To change the frequency of submitting a Patient Status Form to once every 6 months for a hospice patient, the prescriber must sign below:

By signing below, I attest that the above is a hospice care patient.

Prescriber Signature: _____ **Date (MM/DD/YYYY):** _____