

Instructions

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

To submit this form via fax, please complete all required fields below and fax to 844-404-8876. You will receive a confirmation via the contact preference you list below.

Clozapine is only available through the Clozapine Risk Evaluation and Mitigation Strategy (REMS) Program. In order to access the Clozapine Program as a prescriber's designee, you must complete this form.

If you have any questions, require additional information, or need further copies of Clozapine REMS Program documents, please visit the program website at www.clozapinerems.com, or call the Clozapine REMS Program at 844-267-8678.

Prescriber Designee Responsibilities

By signing this form, you acknowledge that you will act on behalf of the certified prescriber (identified below) to comply with the Clozapine REMS Program requirements.

I understand:

1. Clozapine is only available through the Clozapine REMS Program and that I must comply with the program requirements
2. There is a risk of severe neutropenia associated with clozapine
3. **For Outpatients:** An ANC must be reported to the Clozapine REMS Program for each patient, and I understand these results must be provided before clozapine can be dispensed
4. **For Inpatients:** An ANC must be reported to the Clozapine REMS Program for each patient within 7 days from the date of the blood draw
5. A certified prescriber must authorize the continuation of clozapine treatment, if the patient has moderate or severe neutropenia before clozapine can be dispensed to a patient
6. Clozapine manufacturers or their agents and contractors may contact me via phone, mail, or email to survey me on the effectiveness of the program requirements for the Clozapine REMS Program
7. Personnel from the Clozapine REMS Program may contact me to gather information or resolve discrepancies or to provide other information related to the Clozapine REMS Program
8. I will not share my credentials for the Clozapine REMS Program website or allow others to sign into the website using my credentials

Designee Information (All Fields Required)

First Name:		Last Name:	
Email:			
Phone:	Ext (opt):	Fax:	
Contact Preference (please select one): <input type="checkbox"/> Email <input type="checkbox"/> Fax			
Prescriber Designee Signature:			Date (MM/DD/YYYY):

Prescriber Information (All Fields Required)

First Name:		Last Name:	
REMS Certification ID (opt):	DEA:	NPI:	
Prescriber Signature:			Date (MM/DD/YYYY):