CLOZAPINE REMS
The Single Shared System for Clozapine
No Blood, No Drug™

Prescriber Enrollment Form

Phone: 844-267-8678
Fax: 844-404-8876
www.clozapinerems.com

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 become certified and prescriber clozapine, you must:

1. Review *Clozapine and the Risk of Neutropenia: A Guide for Healthcare Providers*
2. Successfully complete the *Knowledge Assessment for Healthcare Providers*
3. Complete and submit this one-time *Prescriber Enrollment Form* along with the completed *Knowledge Assessment for Healthcare Providers*

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 Responsibilities

By signing this form, I attest that:

1. I understand that clozapine is only available through the Clozapine REMS Program and that I must comply with the program requirements to prescribe clozapine
2. I have reviewed *Clozapine and the Risk of Neutropenia: A Guide for Healthcare Providers*, reviewed the clozapine Prescribing Information, and successfully completed the *Knowledge Assessment for Healthcare Providers*
3. I understand the risk of severe neutropenia associated with clozapine
4. Prior to initiating treatment, I agree to provide *What You Need To Know About Clozapine: A Guide for Patients and Caregivers* to each patient and/or his/her caregiver. I will review it with him/her to inform them about the risks associated with clozapine, including severe neutropenia and the Clozapine REMS Program requirements – unless I determine that the patient's adherence to the treatment regimen will be negatively impacted by providing *What You Need To Know About Clozapine: A Guide for Patients and Caregivers*
5. I will enroll all patients I treat with a clozapine product in the Clozapine REMS Program
6. I understand the ANC testing and monitoring requirements as described in the clozapine Prescribing Information
7. I understand there is a different ANC monitoring algorithm for patients with Benign Ethnic Neutropenia (BEN)
8. I will order ANC testing for each patient according to the clozapine Prescribing Information
9. I will report the ANC for each patient to the Clozapine REMS Program and I understand the ANC must be provided before clozapine can be dispensed
10. I understand that, as described in *Clozapine and the Risk of Neutropenia: A Guide for Healthcare Providers,* I must authorize the continuation of clozapine treatment if the patient has moderate or severe neutropenia before clozapine can be dispensed
11. I agree that 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
12. I understand that 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
13. I will not share my credentials for the Clozapine REMS Program website or allow others to sign into the website using my credentials

Prescriber Information (All Fields Required Unless Otherwise Indicated)

First Name:	MI (opt):	Last Name:
NPI:		DEA:
Email:		Credentials (MD, DO, NP, PA):
Clinic / Practice Name:		
Address:		
City:	State:	Zip Code:
Phone:	Ext (opt):	Fax:
Contact Preference (please select one): ☐ Email ☐ Fax		
Prescriber's Signature:		**Date (MM/DD/YYYY):**