BUY & BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

BUY & BILL PHARMACY

ZYPREXA Relprevv™ (olanzapine) For Extended Release Injectable Suspension

To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete and fax this form to 1-877-772-9391.

Training must be completed before a pharmacy service provider may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PHARMACY SERVICE PROVIDER INFORMATION

☐ Enrollment ☐ Reenrollment

Facility Name: _____

DEA Number: _____

Please specify description of Pharmacy: ☐ Community/Retail ☐ Specialty Pharmacy ☐ Hospital or Institution ☐ Other

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

SHIP TO INFORMATION

Ship To Address (if the same as above, check here) ☐

Ship To Contact Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

ADMINISTRATOR INFORMATION

First Name: _____ MI: _____ Last Name: _____

Preferred Method of Communication: ☐ Email ☐ Fax

Email: _____

Phone: _____ Fax: _____
(if different from above) (if different from above)

PHARMACY SERVICE PROVIDER AGREEMENT

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff understand that ZYPREXA RELPREVV can only be dispensed for use in certain health care settings (e.g., hospitals, clinics) that have ready access to emergency response services and that can allow for continuous patient monitoring for at least 3 hours post-injection.
- I will ensure that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, **prior to** the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the facility.

_____ Date: ☐☐ – ☐☐ – ☐☐☐☐
Administrator Signature month day year

** Buy & Bill Pharmacy Service Provider - a licensed healthcare provider that purchases pharmaceuticals through a licensed distributor for its own use in the treatment of a patient and then includes the cost of the pharmaceutical in its billing of patients and third-party payers.*

PHONE 1-877-772-9390 **FAX 1-877-772-9391** **www.zyprexarelprevvprogram.com**

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