PRESCRIBER REGISTRATION FORM

PRESCRIBER

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 prescriber may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PRESCRIBER INFORMATION

☐ Enrollment ☐ Reenrollment

First Name: _____ MI: _____ Last Name: _____

Degree: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Nurse with prescriptive authority ☐ Other with prescriptive authority

License Number: _____ State of Issue: _____

Treatment Facility/Practice (Where you see your patients): _____

If you see your patients at multiple locations please contact the ZYPREXA RELPREVV Patient Care Program Coordinating Center to provide additional facility/practice information

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Fax: _____ Prescriber Email: _____

Preferred Method of Communication: ☐ Email ☐ Fax

PRESCRIBER AGREEMENT

By signing below, I acknowledge that:

- I understand the ZYPREXA RELPREVV Patient Care Program requirements and the risks associated with ZYPREXA RELPREVV.
- I have completed the mandatory ZYPREXA RELPREVV training.
- I understand the clinical presentation of post-injection delirium/sedation syndrome (PDSS) and how to manage patients should an event occur while using ZYPREXA RELPREVV;
- I understand that ZYPREXA RELPREVV should only be initiated in patients for whom tolerability with oral olanzapine has been established;
- I understand that ZYPREXA RELPREVV should only be administered to patients in healthcare 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 enroll all patients in the ZYPREXA RELPREVV Patient Care Program registry prior to prescribing ZYPREXA RELPREVV by completing the Patient Registration Form.
- I will ensure all suspected cases of PDSS are reported to the ZYPREXA RELPREVV Patient Care Program within 24 hours of becoming aware of the event.
- I will review the ZYPREXA RELPREVV Medication Guide with each patient prior to prescribing.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact me to resolve discrepancies, to obtain information about a patient, or to conduct occasional surveys.

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 revoke my registration, I will no longer be eligible to prescribe ZYPREXA RELPREVV.

Lilly may disenroll prescribers that are non-compliant with the program requirements.

_____ Date: ☐☐ – ☐☐ – ☐☐☐☐

Prescriber Signature — month — day — year

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