

**Instructions for Prescribers**

For immediate enrollment, please go to [www.clozapinerems.com](http://www.clozapinerems.com).

For enrollment via fax, please complete all required fields below and fax to 844-404-8876. For enrollment via the contact center, please call 844-267-8678. Enrollment confirmation will be sent via the contact preference specified on the prescriber's *Clozapine REMS Prescriber Enrollment Form*.

**Complete this form for a patient if:**

- This patient has never been treated with clozapine previously, OR
- If you have never treated this patient with clozapine (regardless of the patient's history of clozapine treatment)

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

1. Provide the patient or caregiver with *What You Need To Know About Clozapine: A Guide for Patients and Caregivers*
2. Inform the patient or caregiver about the risk of severe neutropenia with clozapine and the Clozapine REMS Program requirements unless you determine that the patient's adherence to the treatment regimen will be negatively impacted by providing the *What You Need To Know About Clozapine: A Guide for Patients and Caregivers* and informing them about this risk.
3. Complete and submit this *Clozapine REMS Patient Enrollment 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](http://www.clozapinerems.com), or call the Clozapine REMS Program at 844-267-8678.

**PATIENT INFORMATION** (All fields required for Enrollment)

First Name:	Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:	
Date of Birth (MM/DD/YYYY):	Zip Code:
Is this patient actively on clozapine therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**LAB INFORMATION** (ANC must be provided before clozapine is dispensed, but is not required for patient enrollment)

Blood Draw Date (MM/DD/YYYY):	ANC (per $\mu$ L):
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**PRESCRIBER INFORMATION** (All Fields Required)

Name:		
NPI or DEA:		
Phone:	Email:	Fax:
Submitter: <input type="checkbox"/> Prescriber <input type="checkbox"/> Prescriber Designee		

**BENIGN ETHNIC NEUTROPENIA (BEN) PATIENT ATTESTATION\*** (Signature required only for attestation of BEN diagnosis)

By signing below, I attest that the above patient has Benign Ethnic Neutropenia (BEN).

Prescriber Signature:	Date (MM/DD/YYYY):
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\*Enrollment for patients with BEN must be completed by faxing this signed document to 844-404-8876 or by accessing the Clozapine REMS Program website at [www.clozapinerems.com](http://www.clozapinerems.com).