

**Instructions**

For immediate certification, please go to [www.clozapinerems.com](http://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 prescribe clozapine, you must:**

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

If you have any questions, require additional information, or need copies of Clozapine REMS Program documents, please visit the Clozapine REMS Program Website at [www.clozapinerems.com](http://www.clozapinerems.com) or call the Clozapine REMS Program Contact Center 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 *Clozapine REMS Knowledge Assessment for Healthcare Providers*.
3. I understand the risk of severe neutropenia associated with clozapine which can lead to serious infection and death.
4. Prior to initiating treatment, I agree to provide *A Guide for Patients and Caregivers: What You Need to Know about Clozapine* 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 *A Guide for Patients and Caregivers: What You Need to Know about Clozapine*.
5. I will enroll all patients I treat with a clozapine product in the Clozapine REMS Program.
6. I understand the absolute neutrophil count (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 documented benign ethnic neutropenia (BEN).
8. I will order ANC testing for each patient according to the clozapine Prescribing Information.
9. I will submit and verify the ANC according to each patient's monitoring frequency on file with the Clozapine REMS Program and I understand the ANC must be provided before clozapine can be dispensed.
  - For weekly monitoring frequency, ANC must be submitted to the Clozapine REMS Program within 7 days of the lab draw\* date
  - For every two weeks monitoring frequency, ANC must be submitted to the Clozapine REMS Program within 15 days of the lab draw\* date
  - For monthly monitoring frequency, ANC must be submitted to the Clozapine REMS Program within 31 days of lab draw\* date

\*Assumes the lab draw date is day 0
10. I will verify the patient's monitoring frequency on file with the Clozapine REMS Program is aligned with the patient's monitoring frequency as described in the Prescribing Information.
11. 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.
12. I agree that personnel from the Clozapine REMS Program or a designated third party acting on behalf of the Clozapine Sponsors may contact me to gather information, resolve discrepancies, or to provide other information related to the Clozapine REMS Program.
13. 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.
14. I will not share my credentials for the Clozapine REMS Program Website or allow others to sign in to 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): <input type="checkbox"/> Email <input type="checkbox"/> Fax		
Prescriber's Signature: _____		Date (MM/DD/YYYY): _____

<sup>1</sup>Prescribers who prescribe clozapine only to patients receiving inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition) are not required to be certified in the Clozapine REMS Program. Patients in this setting are required to be enrolled in the Clozapine REMS Program in order to receive clozapine. If a patient in this setting is not enrolled, they must be enrolled by a certified prescriber before they will be allowed to receive clozapine.