

ZULRESSO™ REMS Patient Enrollment Form

INSTRUCTIONS

Complete and fax this form to the ZULRESSO REMS at 833-564-7243 or email this form to information@zulressorems.com.

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Date of Birth (MM/DD/YYYY)	/	/
Address 1			Address 2		
City		State	ZIP		
Email Address			Phone Number		

By signing this form, you agree to the following:

- I have received, read, and understand the *Patient Information Guide* that my Healthcare Provider has given me.
- My Healthcare Provider has counseled me on:**
- The side effects of excessive sleepiness (excessive sedation) and passing out (loss of consciousness)
 - The signs and symptoms of excessive sleepiness (excessive sedation) and passing out (loss of consciousness)
 - The need to be monitored for these effects at a Healthcare Setting for the entire 60 hours of infusion
 - I will tell my Healthcare Provider if I am having any of these signs of extreme sleepiness:
 - Feeling overly tired
 - Feeling like I cannot stay awake during normal activities
 - Feeling like I will pass out

I understand:

- I will be monitored for extreme sleepiness, passing out, and low oxygen levels in my body.
- This risk means that I must be accompanied during all interactions with my child(ren) for the entire time of the infusion.
- My personal information will be shared to enroll me in the ZULRESSO REMS.
- Sage Therapeutics, Inc. and its agents, may contact me by phone, mail, or email to manage the ZULRESSO REMS.
- Sage Therapeutics, Inc. and its agents, may use and share my personal health information to manage the ZULRESSO REMS, including enrolling me into and managing the ZULRESSO REMS, coordinating the dispensing of ZULRESSO, and releasing and sharing my personal health information to the U.S. Food and Drug Administration (FDA), as necessary.

SIGN
HERE

DATE
HERE

Date (MM/DD/YYYY)

PRESCRIBER INFORMATION

First Name	Last Name
Prescriber National Provider Identifier (NPI#)	Prescriber Credentials <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other
	Prescriber Specialty <input type="checkbox"/> Psychiatry <input type="checkbox"/> OB/GYN <input type="checkbox"/> Family Practice <input type="checkbox"/> Other
DEA Number	Phone Number

ADMINISTERING HEALTHCARE SETTING INFORMATION (Healthcare Provider is the person who is assisting the patient with completing this form.)

Healthcare Setting Name		Specific Department/Location
Healthcare Provider First Name	Healthcare Provider Last Name	Title
Address 1		Address 2
City		State ZIP
Phone Number		Fax Number
A Pharmacy Outside My Institution Will Be Utilized to Prepare ZULRESSO for This Patient <input type="checkbox"/>		

SIGN
HERE

DATE
HERE

Date (MM/DD/YYYY)

Please visit www.zulressorems.com or call 844-472-4379 for more information about the ZULRESSO REMS.



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