

# ZULRESSO™ REMS Pharmacy Enrollment Form

## INSTRUCTIONS

If your Healthcare Setting and Pharmacy are within the same institution, enroll as a Healthcare Setting only.

1. Review REMS Program Overview
2. Review and complete this Pharmacy Enrollment Form
3. Submit completed form online to the ZULRESSO REMS through the REMS Website at [www.zulressorems.com](http://www.zulressorems.com), by fax to 833-564-7243, or by email to [information@zulressorems.com](mailto:information@zulressorems.com). You can also mail this form to 7751 Brier Creek Parkway, Suite 200, Raleigh, NC 27617.

## PHARMACY INFORMATION

Pharmacy Name		Pharmacy Type: <input type="checkbox"/> Specialty <input type="checkbox"/> Specialty Infusion <input type="checkbox"/> Compounding <input type="checkbox"/> Other	
National Council for Prescription Drug Program ID (NCPDP)	Pharmacy DEA Number	National Provider Identifier (NPI #)	
Address			
City	State	ZIP	

Your Pharmacy information will be shared with Sage Therapeutics, Inc.'s patient support and distribution partners, to allow your Pharmacy to purchase product.

## AUTHORIZED REPRESENTATIVE INFORMATION

Name		Title	
Credentials		Reason for Form: <input type="checkbox"/> New Enrollment <input type="checkbox"/> New Representative	
Phone Number	Fax Number	Email Address	
Address			
City	State	ZIP	

## PHARMACY ATTESTATIONS

As the Authorized Pharmacy Representative, I attest that:

- I have reviewed the *Program Overview*.
- I must complete the *Pharmacy Enrollment Form* and submit it to the ZULRESSO REMS.
- I agree to train all relevant staff involved in dispensing that ZULRESSO must only be dispensed to a certified Healthcare Setting.
- I agree to put processes and procedures in place to verify, prior to dispensing ZULRESSO, that the Healthcare Setting is certified in the ZULRESSO REMS.
- I agree not to distribute, transfer, loan, or sell ZULRESSO.
- I will maintain records documenting staff's completion of training.
- I will maintain records that all REMS processes and procedures are in place and being followed.
- I will maintain records of all shipments of ZULRESSO received and dispensing information including patient name, dose, and number of vials.
- I will comply with audits carried out by Sage Therapeutics, Inc. or third party acting on behalf of Sage Therapeutics to ensure that all processes and procedures are in place and are being followed.

SIGN  
HERE

DATE  
HERE

Date (MM/DD/YYYY)

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## ADDITIONAL PHARMACY LOCATIONS TO BE ENROLLED (OPTIONAL)

Pharmacy Location Name		Pharmacy Type: <input type="checkbox"/> Specialty <input type="checkbox"/> Specialty Infusion <input type="checkbox"/> Compounding <input type="checkbox"/> Other	
National Council for Prescription Drug Program ID (NCPDP)	Pharmacy DEA Number	National Provider Identifier (NPI #)	
Address			
City	State	ZIP	

Pharmacy Location Name		Pharmacy Type: <input type="checkbox"/> Specialty <input type="checkbox"/> Specialty Infusion <input type="checkbox"/> Compounding <input type="checkbox"/> Other	
National Council for Prescription Drug Program ID (NCPDP)	Pharmacy DEA Number	National Provider Identifier (NPI #)	
Address			
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Pharmacy Location Name		Pharmacy Type: <input type="checkbox"/> Specialty <input type="checkbox"/> Specialty Infusion <input type="checkbox"/> Compounding <input type="checkbox"/> Other	
National Council for Prescription Drug Program ID (NCPDP)	Pharmacy DEA Number	National Provider Identifier (NPI #)	
Address			
City	State	ZIP	

Please visit [www.zulressoems.com](http://www.zulressoems.com) or call 844-472-4379 for more information about the ZULRESSO REMS.



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