

ZULRESSO™ REMS Post Infusion Form

INSTRUCTIONS

ZULRESSO is only available through the ZULRESSO Risk Evaluation and Mitigation Strategy (REMS). A Post Infusion Form must be submitted to the ZULRESSO REMS for all patients who are enrolled in the ZULRESSO REMS. Please complete and submit this form within 3 business days of the patient completing the infusion or the scheduled infusion completion date.

You can submit this form online to the ZULRESSO REMS through the REMS Website at www.zulressorems.com, by fax to 833-564-7243, or by email to information@zulressorems.com. You may be contacted for further information on any reported events by the ZULRESSO REMS team.

PATIENT AND HEALTHCARE SETTING INFORMATION

All fields are required unless otherwise indicated.

Patient First Name	Middle Initial	Patient Last Name	
Patient Date of Birth (MM/DD/YYYY)		REMS ID	
Healthcare Setting Where ZULRESSO Was Administered or Was Scheduled to Be Administered (Include Address Below)			
Address		City	State ZIP
Phone Number		Email (Optional)	

HEALTHCARE PROVIDER (HCP) INFORMATION

All fields are required unless otherwise indicated.
The HCP identified below may be contacted for further information.

First Name	Last Name
Credentials: <input type="checkbox"/> MD/DO <input type="checkbox"/> NP/PA <input type="checkbox"/> Pharmacist <input type="checkbox"/> Nurse <input type="checkbox"/> Other	Specialty: <input type="checkbox"/> Psychiatry <input type="checkbox"/> OB/GYN <input type="checkbox"/> Family Practice <input type="checkbox"/> Other
Did the Patient Receive ZULRESSO? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please check all reasons that apply: <input type="checkbox"/> Logistical challenges <input type="checkbox"/> Change in treatment plan <input type="checkbox"/> Other	
If Yes, Please Complete Below	
Date Infusion Started (MM/DD/YYYY)	Time Infusion Started (24-Hour Clock HH:MM) :
Date Infusion Ended (MM/DD/YYYY)	Time Infusion Ended (24-Hour Clock HH:MM) :
Did the Patient Experience Loss of Consciousness While on ZULRESSO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the Patient Experience Excessive Sedation While on ZULRESSO? <input type="checkbox"/> Yes <input type="checkbox"/> No
If You Answer Yes to Either of the Above Questions, Complete the Excessive Sedation and Loss of Consciousness Adverse Event Form*	
Administering HCP Signature	Date (MM/DD/YYYY)
HCP Email (Optional)	HCP Phone Number

*If you have any questions, require additional information, or need additional copies of any of the ZULRESSO REMS documents, please visit the ZULRESSO REMS website at www.zulressorems.com or call 844-472-4379.

Healthcare Providers must report to the ZULRESSO REMS any event of excessive sedation or loss of consciousness using the Excessive Sedation and Loss of Consciousness Adverse Event Form.

**To report any SUSPECTED ADVERSE REACTIONS, contact Sage Therapeutics, Inc.
at 844-472-4379 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.**



ZULRESSO, the ZULRESSO logo, SAGE THERAPEUTICS, and the SAGE THERAPEUTICS logo are trademarks of Sage Therapeutics, Inc. All other trademarks referenced herein are the properties of their respective owners.
©2019 Sage Therapeutics, Inc. All rights reserved.

