

# PATIENT REGISTRATION FORM



To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete and fax this form to 1-877-772-9391.

## PATIENT INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Race:  White  Black or African American  Native Hawaiian or Other Pacific Islander  
 Asian  American Indian or Alaska Native  Other

Ethnicity:  Hispanic or Latino  
 Non-Hispanic/Non-Latino

## PRESCRIBER INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Treatment Facility/Practice Name (where you see the patient): \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

Will the patient be injected/monitored at your facility/practice?

Yes

No (If No, complete next section)

## INJECTING/MONITORING FACILITY INFORMATION

Facility Name (where the patient receives injections or monitoring): \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PATIENT AGREEMENT**

The maker of ZYPREXA RELPREVV, Eli Lilly and Company and their delegates run the ZYPREXA RELPREVV Patient Care Program.

Your doctor will send your name, date of birth, and other information that directly identifies you to the ZYPREXA RELPREVV Patient Care Program. Ask your doctor if you have questions about the information that will be collected.

The ZYPREXA RELPREVV Patient Care Program will collect and use your information in the following ways:

- Your doctor will provide dose, date and time of each injection, and other medical information to the ZYPREXA RELPREVV Patient Care Program.
- Your information will be stored in the ZYPREXA RELPREVV Patient Care Program computer system.
- The information will be used to help Lilly learn more about the safety of ZYPREXA RELPREVV.
- Information from all patients in the ZYPREXA RELPREVV Patient Care Program will be reviewed and may be combined with information from clinical studies.
- This combined information will not be able to identify you or any other patient. This combined information may be shared with:
  - regulatory agencies,
  - doctors at other institutions,
  - the committee overseeing the ZYPREXA RELPREVV Patient Care Program, and/or
  - publications or as part of scientific discussions.

Also, by signing this form you agree to the following:

- I understand that I must enroll in the ZYPREXA RELPREVV Patient Care Program registry to get ZYPREXA RELPREVV.
- I agree to have my information entered in the ZYPREXA RELPREVV Patient Care Program registry.
- My doctor has explained the risks and benefits of treatment with ZYPREXA RELPREVV.
- I have received a copy of the Medication Guide.
- I understand that I will be observed at the clinic for 3 hours after each injection.
- Someone must go with me to my destination when I leave the clinic.
- I understand that I can not drive or use heavy machinery for the rest of the day on which I get an injection.
- I agree to seek medical care right away if I have a reaction such as excessive sleepiness, dizziness, confusion, difficulty talking, difficulty walking, muscle stiffness or shaking, weakness, irritability, aggression, anxiety, increase in blood pressure or convulsions.
- I agree to contact my doctor if I have a reaction to ZYPREXA RELPREVV.
- I may be asked to complete occasional surveys about my understanding of the risks and benefits of treatment with ZYPREXA RELPREVV.
- I or my caregiver have discussed any questions or concerns about my treatment with ZYPREXA RELPREVV with my doctor.

You may stop participating in the ZYPREXA RELPREVV Patient Care Program at any time by telling your doctor. If you stop participating, you will no longer be able to receive the drug. Your doctor will no longer provide any of your information to the ZYPREXA RELPREVV Patient Care Program except to answer safety questions. The ZYPREXA RELPREVV Patient Care Program will still use information that was collected before you stopped participating. You will be provided a copy of this form.

\_\_\_\_\_  
Signature

Date: 

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month                  day                  year

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Legal Guardian (if applicable)

Check the box if the patient has not signed due to enrollment decision being made by prescriber who is authorized via a court order.  
Date of Court Order Expiration (MMDDYYYY) \_\_\_\_\_

This patient has been shown to be tolerant of oral olanzapine.

\_\_\_\_\_  
Signature of Prescriber

Date: 

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month                  day                  year

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Printed Name of Prescriber

