

# HEALTHCARE FACILITY REGISTRATION FORM



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

Training must be completed before a healthcare facility may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

## HEALTHCARE FACILITY INFORMATION

Enrollment  Reenrollment

Healthcare Facility Name: \_\_\_\_\_

Please specify location of Healthcare Facilities:  Prescriber Office  Clinic/Outpatient Facility  Hospital  Other

Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## AUTHORIZED HEALTHCARE FACILITY REPRESENTATIVE INFORMATION

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

Position/Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Communication:  Email  Fax

You may identify Delegate(s) to enter the necessary patient data into the Patient Care Program system.

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

Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(if different from above) (if different from above)

Email: \_\_\_\_\_

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

Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(if different from above) (if different from above)

Email: \_\_\_\_\_

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

Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(if different from above) (if different from above)

Email: \_\_\_\_\_

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

Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(if different from above) (if different from above)

Email: \_\_\_\_\_

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

Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(if different from above) (if different from above)

Email: \_\_\_\_\_

If additional Delegates are required contact the the Patient Care Program Coordinating Center.

PHONE 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com



# HEALTHCARE FACILITY REGISTRATION FORM

## HEALTHCARE FACILITY AGREEMENT

As the authorized representative for this facility, I attest that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure;
- I will ensure that all appropriate staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure as well as the following Training Materials:
  - ZYPREXA RELPREVV Healthcare Professional Training
  - ZYPREXA RELPREVV Reconstitution and Administration Training
- I will ensure that all appropriate staff understand that ZYPREXA RELPREVV can only be dispensed for use in certain health care settings (e.g., hospitals, clinics) that have ready access to emergency response services and that can allow for continuous patient monitoring for at least 3 hours post-injection;
- I will ensure the health care setting has systems, protocols, or other measures to ensure that ZYPREXA RELPREVV is only administered to patients enrolled in the program and that patients are continuously monitored for at least 3 hours post-injection for suspected PDSS;
- I will ensure that appropriate staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to each injection, by accessing the system;
- I will ensure that the Medication Guide is provided to the patient or the patient's legal guardian prior to each injection;
- I will ensure that the appropriate staff monitors the patient continuously for at least 3 hours;
- I will ensure that required data are submitted within 7 days after each injection to the ZYPREXA RELPREVV Patient Care Program.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the health care setting to clarify information provided or to obtain information about the patient.

I confirm that the information above is correct.

I understand that this information will be used to document healthcare facilities that are eligible to administer ZYPREXA RELPREVV.

I also understand that this information may be shared with government agencies.

I understand that Lilly will regularly evaluate ZYPREXA RELPREVV Patient Care Program compliance to ensure that program objectives are met. Lilly reserves the right to terminate a healthcare facility's enrollment at any time based upon non-compliance or to take other appropriate measures to assure that the ZYPREXA RELPREVV Patient Care Program objectives are met.

I may cancel this healthcare facility registration in the future by notifying Lilly in writing and submitting the notification by fax to 1-877-772-9391 or by calling 1-877-772-9390. If I revoke this facility's registration, the facility will no longer be eligible to administer ZYPREXA RELPREVV to patients.

\_\_\_\_\_  
Authorized Healthcare Facility Representative Signature

Date:

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month			day			year			

Authorized Healthcare Facility Representative Name (print) \_\_\_\_\_ Title \_\_\_\_\_

Please fax completed form to the ZYPREXA RELPREVV Patient Care Program at 1-877-772-9391.

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FAX 1-877-772-9391

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