

Welcome to the ZYPREXA RELPREVV Patient Care Program

The goal of the ZYPREXA RELPREVV Patient Care Program is to mitigate the risk of negative outcomes associated with ZYPREXA RELPREVV post-injection delirium/sedation syndrome (PDSS).

For a tour of the ZYPREXA RELPREVV Patient Care Program system [click here](#).

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[Prescribing Information](#)

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[Registration Forms](#)

[Medication Guide](#)

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[Order Educational Materials](#)

[Pharmacy Finder](#)

Please see Prescribing Information for full details about the risks of ZYPREXA RELPREVV, including Boxed Warnings.

This site is intended for U.S. residents age 18 and over.

For more information about ZYPREXA RELPREVV, contact your doctor or other healthcare professional.

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zyprexaRelprevv
(olanzapine) For Extended Release
Injectable Suspension

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https://training.zyprexa.com

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AIM Reimbursement-PAP ... Amgen NBU - Home Approved Risk Evaluation ... Backlog items

ZYPREXA RELPREVV Patient Care Program

Getting started with the Zyprexa Relprevv Patient Care Program and the 3 steps to enrollment.

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ZYPREXA RELPREVV Patient Care Program

On-line Training

ON-LINE TRAINING

Select your role(s) from the list below to access required training.

Prescriber

Healthcare Facility Staff

Pharmacy Service Providers (pharmacies and
buy & bill pharmacy service providers)

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ZYPREXA RELPREVV Patient Care Program

Required Prescriber Training

1. [ZYPREXA RELPREVV Patient Care Program Instructions Brochure](#)
 2. Healthcare Professional Training (*select one*)
 - [Slide Presentation](#)
- OR
- [Recorded Presentation](#)

ADDITIONAL RESOURCES

[Post-Injection Delirium/Sedation Syndrome Case Study Video](#)

Once you have completed the required training, submit the appropriate [registration form](#).

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ZYPREXA RELPREVV Patient Care Program

ZYPREXA RELPREVV Patient Care Program Instructions Brochure

Required Prescriber Training

- ZYPREXA RELPREVV Pa**
- Healthcare Professional T
 - Slide Presentation**

OR

- Recorded Presentation**

ADDITIONAL RESOURCES

Post-Injection Delirium/Sedation Syr

Once you have completed the required tra

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ZYPREXA RELPREVV Patient Care Program

Required Prescriber Training

1. **ZYPREXA RELPREVV**
 2. Healthcare Professional
 - **Slide Presentation**
- OR
- **Recorded Presentation**

ADDITIONAL RESOURCES

Post-Injection Delirium/Sedation

Once you have completed the require

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Training Presentation

ZYPREXA RELPREVV
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Injectable Suspension

Training for Healthcare Professionals

Please see the Prescribing Information and the Reconstitution and Administration Poster before using ZYPREXA RELPREVV

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ZYPREXA Relprevv
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The goal of this presentation is to educate healthcare professionals in an effort to mitigate negative outcomes associated with ZYPREXA RELPREVV post-injection delirium/sedation syndrome (PDSS). Healthcare professionals include: physicians, nurses and any other professionals who will be involved with the care of the patient receiving the injection.

Please see the Prescribing Information and the Reconstitution and Administration Poster

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ZYPREXA RELPREVV Patient Care Program

Required Prescriber Training

1. **ZYPREXA RELPREVV P**
 2. Healthcare Professional T
- **Slide Presentation**
- OR
- **Recorded Presentation**

ADDITIONAL RESOURCES

[Post-Injection Delirium/Sedation Syndrome Case](#)

Once you have completed the required training, submit

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HCP_ROM - Internet Explorer
https://zyprexa.dev.ubcpsc.com/public/home.htm



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Training for Healthcare Professionals

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Required Prescriber Training

Post-Injection Delirium/Sedation Syndrome Case Study Video

ZYPREXA Relprevv
(olanzapine) For Extended Release
Injectable Suspension
210 mg/vial, 300 mg/vial, and 405 mg/vial

Post-Injection Delirium/Sedation Syndrome Case Study Video

00:00:07 / 00:39:19

ADDITIONAL

Post-Injection

Once you

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ZYPREXA RELPREVV Patient Care Program

Required Healthcare Facility Staff Training

• **REQUIRED TRAINING FOR STAFF ADMINISTERING INJECTIONS AND STAFF WHO MONITOR PATIENTS**

1. **Healthcare Professional Training** (*select one*)

- [Slide Presentation](#)

OR

- [Recorded Presentation](#)

2. **ZYPREXA RELPREVV Patient Care Program Instructions Brochure**

• **REQUIRED ADDITIONAL TRAINING FOR STAFF ADMINISTERING INJECTIONS**

3. **Reconstitution & Administration Instruction**

- [Training Video](#)

AND

- [Poster](#) (view and/or print)

ADDITIONAL RESOURCES

Post-Injection Delirium/Sedation Syndrome Case Study Video

Once all the appropriate staff from a healthcare facility have completed the required training, a representative from the facility must submit the **Healthcare Facility Registration Form**.

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ZYPREXA RELPREVV Patient Care Program

Required Healthcare Facility Staff Training

• REQUIRED TRAINING FOR STAFF ADMINISTERING INJECTIONS AND STAFF WHO MONITOR PATIENTS

1. Healthcare Professional Training (select one)

- [Slide Presentation](#)

OR

Training Presentation

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Training for Healthcare Professionals

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ZYPREXA RELPREVV Patient Care Program

Required Healthcare Facility Staff Training

The screenshot shows a web browser window with the following elements:

- Address Bar:** <https://training.zyprexa...>
- Page Title:** ZYPREXA RELPREVV Patient Care Program Instructions Brochure
- Main Content:**

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- Footer (partially visible):**

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ZYPREXA RELPREVV Patient Care Program

Required Healthcare Facility Staff Training

• REQUIRED TRAINING FOR STAFF ADMINISTERING INJECTIONS AND STAFF WHO MONITOR PATIENTS

1. 
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Post-Injection Delirium/Sedation Syndrome Case Study Video

Once all the appropriate staff from a healthcare facility have completed the required training, a representative from the facility must submit the **Healthcare Facility Registration Form**.

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ZYPREXA RELPREVV Patient Care Program

Required Healthcare Facility Staff Training

• REQUIRED TRAINING FOR STAFF ADMINISTERING INJECTIONS AND STAFF WHO MONITOR PATIENTS

1. Healthcare Professional Training (select one)

Instructions to Reconstitute and Administer ZYPREXA RELPREVV

FOR DEEP INTRAMUSCULAR GLUTEAL INJECTION ONLY. NOT TO BE INJECTED INTRAVENOUSLY OR SUBCUTANEOUSLY.

For Important Safety Information, including boxed warnings, see the full Prescribing Information provided.

STEP 1 PREPARING MATERIALS

Convenience kit includes:
(See Figure 1 on left)

- Vial of ZYPREXA RELPREVV powder
- 3-mL vial of diluent
- One 3-mL syringe with pre-attached 19-gauge, 1.5-inch (38 mm) Hypodermic Needle-Pro® needle with needle protection device
- Two 19-gauge, 1.5-inch (38 mm) Hypodermic Needle-Pro needles with needle protection device.
 - For obese patients, a 2-inch (50 mm), 19-gauge or larger needle (not included in convenience kit) may be used for administration.

! ZYPREXA RELPREVV must be suspended using only the diluent supplied in the convenience kit.

It is recommended that gloves are used when reconstituting, as ZYPREXA RELPREVV may be irritating to the skin. Flush with water if contact is made with skin.

STEP 2 DETERMINING RECONSTITUTION VOLUME

Dose	Vial Strength	Diluent to Add
150 mg	210 mg	1.5 mL
210 mg	210 mg	1.5 mL
300 mg	300 mg	1.8 mL
405 mg	495 mg	2.3 mL

Refer to the table at left to determine the amount of diluent to be added to powder for reconstitution of each vial strength.

! It is important to note that there is more diluent in the vial than is needed to reconstitute.

STEP 3 RECONSTITUTING ZYPREXA RELPREVV

- 3.1 Loosen the powder by lightly tapping the vial.
- 3.2 Open the prepackaged Hypodermic Needle-Pro syringe and needle with needle protection device.
- 3.3 Withdraw the pre-determined diluent volume (Step 2) into the syringe.

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Required Healthcare Facility Staff Training

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ZYPREXA RELPREVV Patient Care Program

Required Pharmacy Service Provider Training

1. ZYPREXA RELPREVV Patient Care Program Instructions Brochure

It is the responsibility of the pharmacy service provider representative to assure that all staff involved with dispensing ZYPREXA RELPREVV have reviewed the ZYPREXA RELPREVV Patient Care Program Instructions Brochure prior to submitting one of the registration forms below.

- **Pharmacy Registration Form**

OR

- **Buy & Bill Pharmacy Service Provider* Registration Form**

* Buy & Bill Pharmacy Service Provider - a licensed healthcare provider that purchases pharmaceuticals through a licensed distributor for its own use in the treatment of a patient and then includes the cost of the pharmaceutical in its billing of patients and third-party payers.

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Required Pharmacy Service Provider Training

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- Footer (Left Side):**

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ZYPREXA RELPREVV Patient Care Program

Registration Forms

Prior to selecting and completing a registration form listed below, please ensure you have completed the appropriate training. To complete training on-line, select the "On-line Training" link below, or to receive materials in hard copy, select the "Order Educational Materials" link below.

[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration Form](#)

[Patient Registration Form](#)

- *[Patient Copy](#)*

[Healthcare Facility Registration Form](#)

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ZYPREXA RELPREVV Patient Care Program

Registration Forms

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[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration](#)

[Patient Registration Form](#)

- [Patient Copy](#)

[Healthcare Facility Registration Form](#)

Registration Type

Do you want to complete your registration on-line or print a registration form?

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ZYPREXA RELPREVV Patient Care Program

PRESCRIBER REGISTRATION FORM

PRESCRIBER REGISTRATION FORM

ZYPREXA RELPREVV
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Injectable Suspension

To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete this form.
Training must be completed before a prescriber may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PRESCRIBER INFORMATION

Enrollment Reenrollment

First Name: **MI:** **Last Name:**

Degree: MD DO NP PA Nurse with prescriptive authority Other with prescriptive authority

License Number: **State of Issue:**

Treatment Facility/Practice (where you see your patients):
If you see your patients at multiple locations please contact the ZYPREXA RELPREVV Patient Care Program Coordinating Center to provide additional facility/practice information

Address Line 1:

Address Line 2:

City: **State:** **Zip:**

Phone: **Alternate Phone:**

Fax: **Prescriber Email:**

Preferred Method of Communication: Email Fax

PRESCRIBER AGREEMENT

By signing below, I acknowledge that:
 I understand the ZYPREXA RELPREVV Patient Care Program requirements and the risks associated with ZYPREXA RELPREVV.

/registration/SelfRegister.aspx?TID=3

ZYPREXA RELPREVV Patient Care Program

PRESCRIBER REGISTRATION FORM

By signing below, I acknowledge that:

- I understand the ZYPREXA RELPREVV Patient Care Program requirements and the risks associated with ZYPREXA RELPREVV.
- I have completed the mandatory ZYPREXA RELPREVV training.
- I understand the clinical presentation of post-injection delirium/sedation syndrome (PDSS) and how to manage patients should an event occur while using ZYPREXA RELPREVV;
- I understand that ZYPREXA RELPREVV should only be initiated in patients for whom tolerability with oral olanzapine has been established;
- I understand that ZYPREXA RELPREVV should only be administered to patients in healthcare 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 enroll all patients in the ZYPREXA RELPREVV Patient Care Program registry prior to prescribing ZYPREXA RELPREVV by completing the Patient Registration Form.
- I will ensure all suspected cases of PDSS are reported to the ZYPREXA RELPREVV Patient Care Program within 24 hours of becoming aware of the event.
- I will review the ZYPREXA RELPREVV Medication Guide with each patient prior to prescribing.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact me to resolve discrepancies, to obtain information about a patient, or to conduct occasional surveys.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390.

If I revoke my registration, I will no longer be eligible to prescribe ZYPREXA RELPREVV.

Lilly may disenroll prescribers that are non-compliant with the program requirements.

- I, attest that I am the Prescriber, and understand that by clicking submit the information provided on this form is true and accurate.

State License Number:

Submit

Cancel

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelpvprogram.com

/registration/SelfRegister.aspx?TID=3

ZYPREXA RELPREVV Patient Care Program

PRESCRIBER REGISTRATION FORM

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State License Number:

Phone 1-877-772-9390

FAX 1-877-772-9391

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/registration/SelfRegister.aspx?TID=3

Confirm Close Window

Enrollment data will not be retained if you leave the enrollment process without submission.

ZYPREXA RELPREVV Patient Care Program

75% Collaborate Sign 1 / 1

PRESCRIBER REGISTRATION FORM

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

PRESCRIBER INFORMATION

Enrollment Reenrollment

First Name: _____ MI: _____ Last Name: _____

Degree: MD DO NP PA Nurse with prescriptive authority Other with prescriptive authority

License Number: _____ State of Issue: _____

Treatment Facility/Practice (Where you see your patients): _____
If you see your patients at multiple locations please contact the ZYPREXA RELPREVV Patient Care Program Coordinating Center to provide additional facility/practice information

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Fax: _____ Prescriber Email: _____

Preferred Method of Communication: Email Fax

PRESCRIBER AGREEMENT

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- I have completed the mandatory ZYPREXA RELPREVV training.
- I understand the clinical presentation of post-injection delirium/sedation syndrome (PDSS) and how to manage patients should an event occur while using ZYPREXA RELPREVV;
- I understand that ZYPREXA RELPREVV should only be initiated in patients for whom tolerability with oral olanzapine has been established;

ZYPREXA RELPREVV Patient Care Program

Phone: _____ Prescriber Phone: _____
Fax: _____ Prescriber Email: _____

Preferred Method of Communication: Email Fax

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- I have completed the mandatory ZYPREXA RELPREVV training.
- I understand the clinical presentation of post-injection delirium/sedation syndrome (PDSS) and how to manage patients should an event occur while using ZYPREXA RELPREVV.
- I understand that ZYPREXA RELPREVV should only be initiated in patients for whom tolerability with oral olanzapine has been established.
- I understand that ZYPREXA RELPREVV should only be administered to patients in healthcare 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 enroll all patients in the ZYPREXA RELPREVV Patient Care Program registry prior to prescribing ZYPREXA RELPREVV by completing the Patient Registration Form.
- I will ensure all suspected cases of PDSS are reported to the ZYPREXA RELPREVV Patient Care Program within 24 hours of becoming aware of the event.
- I will review the ZYPREXA RELPREVV Medication Guide with each patient prior to prescribing.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact me to resolve discrepancies, to obtain information about a patient, or to conduct occasional surveys.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390.

If I revoke my registration, I will no longer be eligible to prescribe ZYPREXA RELPREVV.

Lilly may disenroll prescribers that are non-compliant with the program requirements.

Date: - -
month day year

Prescriber Signature

PHONE 1-877-772-9390 **FAX 1-877-772-9391** **www.zyprexarelpvprogram.com**
Version 2.0 03Aug2012 CONFIDENTIAL Page 1 of 1

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ZYPREXA RELPREVV Patient Care Program

Registration Forms

Prior to selecting and completing a registration form listed below, please ensure you have completed the appropriate training. To complete training on-line, select the "On-line Training" link below, or to receive materials in hard copy, select the "Order Educational Materials" link below.

[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration Form](#)

[Patient Registration Form](#)

- [Patient Copy](#)

[Healthcare Facility Registration Form](#)

Registration Type

Do you want to complete your registration on-line or print a registration form?

[PRIVACY POLICY](#)

[TERMS OF USE](#)

ZYPREXA RELPREVV
(olanzapine) For Extended Release
Injectable Suspension

[Home](#) | [On-line Training](#) | [Registration Forms](#) | [Order Educational Materials](#) | [Prescribing Information](#) | [Medication Guide](#)

Please see Prescribing Information for full details about the risks of ZYPREXA RELPREVV, including Boxed Warnings.

This site is intended for U.S. residents age 18 and over.
For more information about ZYPREXA RELPREVV, contact your doctor or other healthcare professional.

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Lilly

ZYPREXA RELPREVV Patient Care Program

PHARMACY REGISTRATION FORM

PHARMACY REGISTRATION FORM



To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete this form.
Training must be completed before a pharmacy may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PHARMACY INFORMATION

Enrollment Reenrollment

Pharmacy/Hospital Name:

Pharmacy DEA Number:

Please specify description of Pharmacy:

Community / Retail Specialty Pharmacy Hospital or Institution Other

Address Line 1:

Address Line 2:

City: State: Zip:

Primary Phone: Secondary Phone:

Fax:

SHIP TO INFORMATION

Ship To Address (if the same as above check here)

Ship To Contact Name:

Address Line 1:

Address Line 2:

City: State: Zip:

/registration/SelfRegister.aspx?TID=2

ZYPREXA RELPREVV Patient Care Program

PHARMACY REGISTRATION FORM

Primary Phone: () - - Secondary Phone: () - -
Fax: () - -

SHIP TO INFORMATION

Ship To Address (if the same as above check here)
Ship To Contact Name:
Address Line 1:
Address Line 2:
City: State: Zip:
Primary Phone: () - - Secondary Phone: () - -
Fax: () - -

PHARMACIST-IN-CHARGE INFORMATION

First Name: MI: Last Name:
Email:
Phone: () - - Fax: () - -
(if different from above) (if different from above)

PHARMACIST-IN-CHARGE AGREEMENT

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill

/registration/SelfRegister.aspx?TID=2

ZYPREXA RELPREVV Patient Care Program

PHARMACY REGISTRATION FORM

I will ensure that an appropriate pharmacy staff understands 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the pharmacy.

- I, attest that I am the Pharmacist-In-Charge, and understand that by clicking submit the information provided on this form is true and accurate

Confirm DEA #:

Submit

Cancel

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com

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ZYPREXA RELPREVV Patient Care Program

PHARMACY REGISTRATION FORM

I will ensure that an appropriate pharmacy, clinic, ambulatory care center, or hospital 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to support my registration.

I, attest that I am the Pharmacist-In-Charge, and the information provided on this form is true and accurate

Confirm DEA #:

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com

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Confirm Close Window

Enrollment data will not be retained if you leave the enrollment process without submission.

ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 1

PHARMACY REGISTRATION FORM

zyprexaRelprevv
*(olanzapine) For Extended Release
Injectable Suspension*

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 pharmacy may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PHARMACY INFORMATION

Enrollment Reenrollment

Pharmacy/Hospital Name: _____

Pharmacy DEA Number: _____

Please specify description of Pharmacy: Community/Retail Specialty Pharmacy Hospital or Institution Other

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

SHIP TO INFORMATION

Ship To Address (if the same as above, check here)

Ship To Contact Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

PHARMACIST-IN-CHARGE INFORMATION

First Name: _____ MI: _____ Last Name: _____

Email: _____

PHARMACY

ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 1

Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____
Fax: _____

PHARMACIST-IN-CHARGE INFORMATION

First Name: _____ MI: _____ Last Name: _____
Email: _____
Phone: _____ Fax: _____
(if different from above) (if different from above)

PHARMACIST-IN-CHARGE INFORMATION

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the pharmacy.

Pharmacist-in-Charge Signature _____ Date: - -
month day year

PHONE 1-877-772-9390 FAX 1-877-772-9391 www.zyprexareprevvprogram.com

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ZYPREXA RELPREVV Patient Care Program

Registration Forms

Prior to selecting and completing a registration form listed below, please ensure you have completed the appropriate training. To complete training on-line, select the "On-line Training" link below, or to receive materials in hard copy, select the "Order Educational Materials" link below.

[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration](#)

[Patient Registration Form](#)

- [Patient Copy](#)

[Healthcare Facility Registration Form](#)

Registration Type

Do you want to complete your registration on-line or print a registration form?

[PRIVACY POLICY](#)

[TERMS OF USE](#)

ZYPREXA RELPREVV
(olanzapine) For Extended Release
Injectable Suspension

[Home](#) | [On-line Training](#) | [Registration Forms](#) | [Order Educational Materials](#) | [Prescribing Information](#) | [Medication Guide](#)

Please see Prescribing Information for full details about the risks of ZYPREXA RELPREVV, including Boxed Warnings.

This site is intended for U.S. residents age 18 and over.
For more information about ZYPREXA RELPREVV, contact your doctor or other healthcare professional.

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ZYPREXA RELPREVV Patient Care Program

BUY AND BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

BUY AND BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM



To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete this form.
Training must be completed before a pharmacy service provider may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PHARMACY SERVICE PROVIDER INFORMATION

Enrollment Reenrollment

Facility Name:

DEA Number:

Please specify description of Pharmacy:

Community / Retail Specialty Pharmacy Hospital or Institution Other

Address Line 1:

Address Line 2:

City: State: Zip:

Primary Phone: Secondary Phone:

Fax:

SHIP TO INFORMATION

Ship To Address (if the same as above check here)

Ship To Contact Name:

Address Line 1:

Address Line 2:

City: State: Zip:

/registration/SelfRegister.aspx?TID=4

ZYPREXA RELPREVV Patient Care Program

BUY AND BILL™ PHARMACY SERVICE PROVIDER REGISTRATION FORM

City: State: Zip:

Primary Phone: Secondary Phone:

Fax:

ADMINISTRATOR INFORMATION

First Name: MI: Last Name:

Preferred Method of Communication: Email Fax

Email:

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

PHARMACY SERVICE PROVIDER AGREEMENT

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

/registration/SelfRegister.aspx?TID=4

ZYPREXA RELPREVV Patient Care Program

BUY AND BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

PHARMACY SERVICE PROVIDER AGREEMENT

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the facility.

I, attest that I am the Administrator, and understand that by clicking submit the information provided on this form is true and accurate.

Confirm DEA #:

Submit

Cancel

*Buy & Bill Pharmacy Service Provider - a licensed healthcare provider that purchases pharmaceuticals through a licensed distributor for its own use in the treatment of a patient and then includes the cost of the pharmaceutical in its billing of patients and third-party payers.

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com

/registration/SelfRegister.aspx?TID=4

ZYPREXA RELPREVV Patient Care Program

BUY AND BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

PHARMACY SERVICE PROVIDER AGREEMENT

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program is intended to be used by a pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the pharmacy.

at 1-877-772-9391 or by phone at 1-877-772-9390. If

- I, attest that I am the Administrator, and understand that by clicking submit the information provided on this form is true and accurate.

Confirm DEA #:

Submit

Cancel

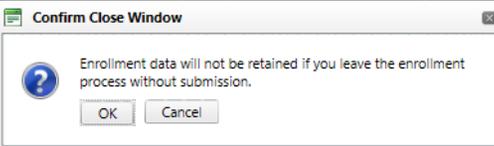
**Buy & Bill Pharmacy Service Provider - a licensed healthcare provider that purchases pharmaceuticals through a licensed distributor for its own use in the treatment of a patient and then includes the cost of the pharmaceutical in its billing of patients and third-party payers.*

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com

/registration/SelfRegister.aspx?TID=4



ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 1

BUY & BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

zyprexaRelprevv
*(olanzapine) For Extended Release
Injectable Suspension*

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 pharmacy service provider may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PHARMACY SERVICE PROVIDER INFORMATION

Enrollment Reenrollment

Facility Name: _____

DEA Number: _____

Please specify description of Pharmacy: Community/Retail Specialty Pharmacy Hospital or Institution Other

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

SHIP TO INFORMATION

Ship To Address (if the same as above, check here)

Ship To Contact Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

ADMINISTRATOR INFORMATION

First Name: _____ MI: _____ Last Name: _____

Preferred Method of Communication: Email Fax

Email: _____

Phone: _____ (if different from above) Fax: _____ (if different from above)

PHARMACY SERVICE PROVIDER AGREEMENT

By signing below, I acknowledge that:

BUY & BILL
PHARMACY

ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 1

SHIP TO INFORMATION

Ship To Address (if the same as above, check here)

Ship To Contact Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Fax: _____

ADMINISTRATOR INFORMATION

First Name: _____ MI: _____ Last Name: _____

Preferred Method of Communication: Email Fax

Email: _____

Phone: _____ Fax: _____
(if different from above) (if different from above)

PHARMACY SERVICE PROVIDER AGREEMENT

By signing below, I acknowledge that:

- I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure.
- I will ensure that all appropriate pharmacy 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 that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system.
- I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients.
- I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program.
- For each dispense I will ensure prescription verification (includes patient eligibility check and recording the dispense date) is completed on the date of dispense, prior to the convenience kit leaving the pharmacy.
- I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the facility.

Administrator Signature _____ Date: - -

month day year

* Buy & Bill Pharmacy Service Provider - a licensed healthcare provider that purchases pharmaceuticals through a licensed distributor for its own use in the treatment of a patient and then includes the cost of the pharmaceutical in its billing of patients and third-party payers.

PHONE 1-877-772-9390 FAX 1-877-772-9391 www.zyprexarelprevvprogram.com

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ZYPREXA RELPREVV Patient Care Program

Registration Forms

Prior to selecting and completing a registration form listed below, please ensure you have completed the appropriate training. To complete training on-line, select the "On-line Training" link below, or to receive materials in hard copy, select the "Order Educational Materials" link below.

[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration](#)

[Patient Registration Form](#)

- [Patient Copy](#)

[Healthcare Facility Registration Form](#)

Registration Type

 Patient Registration Forms are available in PDF format for printing.

[Print](#)

[PRIVACY POLICY](#)

[TERMS OF USE](#)

zyprexaRelprevv
(olanzapine) For Extended Release
Injectable Suspension

[Home](#) | [On-line Training](#) | [Registration Forms](#) | [Order Educational Materials](#) | [Prescribing Information](#) | [Medication Guide](#) |

Please see Prescribing Information for full details about the risks of ZYPREXA RELPREVV, including Boxed Warnings.

This site is intended for U.S. residents age 18 and over.
For more information about ZYPREXA RELPREVV, contact your doctor or other healthcare professional.

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Lilly

75% Collaborate Sign 1 / 2

PATIENT REGISTRATION FORM

zyprexaRelprevv
(olanzapine) For Extended Release
Injectable Suspension

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)

PATIENT page 1 of 2

ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 75% 1 / 2

INJECTING/MONITORING FACILITY INFORMATION

Facility Name (where the patient receives injections or monitoring): _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip: _____

PHONE 1-877-772-9390 FAX 1-877-772-9391 www.zyprexarelprevvprogram.com
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PATIENT REGISTRATION FORM

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:

PATIENT Page 2 of 2

ZYPREXA RELPREVV Patient Care Program

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: - -
month day year

Printed Name of Patient _____

ZYPREXA RELPREVV Patient Care Program

75% Collaborate Sign 2 / 2

- 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: - -
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: - -
month day year

Printed Name of Prescriber _____

PHONE 1-877-772-9390 FAX 1-877-772-9391 www.zyprexareprevvprogram.com

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ZYPREXA RELPREVV Patient Care Program

Registration Forms

Prior to selecting and completing a registration form listed below, please ensure you have completed the appropriate training. To complete training on-line, select the "On-line Training" link below, or to receive materials in hard copy, select the "Order Educational Materials" link below.

[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration](#)

[Patient Registration Form](#)

- [Patient Copy](#)

[Healthcare Facility Registration Form](#)

Registration Type

 Patient Registration Forms are available in PDF format for printing.

[Print](#)

[PRIVACY POLICY](#)

[TERMS OF USE](#)

ZYPREXA Relprevv
(olanzapine) For Extended Release
Injectable Suspension

[Home](#) | [On-line Training](#) | [Registration Forms](#) | [Order Educational Materials](#) | [Prescribing Information](#) | [Medication Guide](#) |

Please see Prescribing Information for full details about the risks of ZYPREXA RELPREVV, including Boxed Warnings.

This site is intended for U.S. residents age 18 and over.
For more information about ZYPREXA RELPREVV, contact your doctor or other healthcare professional.

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ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 1

PATIENT REGISTRATION FORM COPY

zyprexaRelprevv
(olanzapine) For Extended Release
Injectable Suspension

Provide this copy of the ZYPREXA RELPREVV Patient Care Program Patient Registration Form to the patient or guardian upon enrollment.

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Date: _____

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.

PATIENT COPY

ZYPREXA RELPREVV Patient Care Program

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.
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ZYPREXA RELPREVV Patient Care Program

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[Prescriber Registration Form](#)

[Pharmacy Registration Form](#)

[Buy & Bill Pharmacy Service Provider Registration Form](#)

[Patient Registration Form](#)

- [Patient Copy](#)

[Healthcare Facility Registration Form](#)

Registration Type

Do you want to complete your registration on-line or print a registration form?

[PRIVACY POLICY](#)

[TERMS OF USE](#)

ZYPREXA RELPREVV
(olanzapine) For Extended Release
Injectable Suspension

[Home](#) | [On-line Training](#) | [Registration Forms](#) | [Order Educational Materials](#) | [Prescribing Information](#) | [Medication Guide](#)

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ZYPREXA RELPREVV Patient Care Program

HEALTHCARE FACILITY REGISTRATION FORM

HEALTHCARE FACILITY REGISTRATION FORM



To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete this form.
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:

/registration/SelfRegister.aspx?TID=1

ZYPREXA RELPREVV Patient Care Program

HEALTHCARE FACILITY REGISTRATION FORM

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 Coordinating Center.

HEALTHCARE FACILITY AGREEMENT

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

/registration/SelfRegister.aspx?TID=1

ZYPREXA RELPREVV Patient Care Program

HEALTHCARE FACILITY REGISTRATION FORM

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 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

[/registration/SelfRegister.aspx?TID=1](#)

ZYPREXA RELPREVV Patient Care Program

HEALTHCARE FACILITY REGISTRATION FORM

- 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;
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- I will ensure that the appropriate staff monitors the patient continuously for at least 3 hours;
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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.

I, attest that I am the Healthcare Facility Representative, and understand that by clicking submit the information provided on this form is true and accurate.

**Confirm Facility Phone
Number:**

Submit

Cancel

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com

/registration/SelfRegister.aspx?TID=1

ZYPREXA RELPREVV Patient Care Program

HEALTHCARE FACILITY REGISTRATION FORM

- 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 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

I understand that Lilly will regularly evaluate ZYPREXA RELPREVV program objectives are met. Lilly reserves the right to terminate a healthcare facility's enrollment at any time based on 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.

I, attest that I am the Healthcare Facility Representative, and understand that by clicking submit the information provided on this form is true and accurate.

Confirm Facility Phone
Number:

Submit

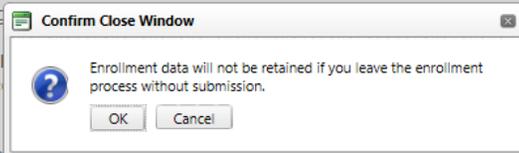
Cancel

Phone 1-877-772-9390

FAX 1-877-772-9391

www.zyprexarelprevvprogram.com

/registration/SelfRegister.aspx?TID=1



ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 2

HEALTHCARE FACILITY REGISTRATION FORM

zyprexaRelprevv
*(olanzapine) For Extended Release
Injectable Suspension*

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)

Email: _____

Delegate First Name: _____ MI: _____ Last Name: _____

Facility Name: _____

Phone: _____ Fax: _____
(if different from above)

HEALTHCARE FACILITY Page 1 of 2

ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 1 / 2

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

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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

HEALTHCARE FACILITY Page 2 of 2

ZYPREXA RELPREVV Patient Care Program

75% Collaborate Sign 2 / 2

- 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.

Date: - -

ZYPREXA RELPREVV Patient Care Program

Collaborate Sign 75% 2 / 2

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.

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_____ Date: - -
month day year

Authorized Healthcare Facility Representative Signature

Authorized Healthcare Facility Representative Name (print) _____ Title _____

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

PHONE 1-877-772-9390	FAX 1-877-772-9391	www.zyprexarelprevvprogram.com
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Order Educational Materials

To order, please complete the information below and click submit.

Requestor Information

First Name: MI: Last Name:

Address Line 1:

Address Line 2:

City: State: Zip:

Phone: Alternate Phone:

Fax: Email:

Please indicate the number of items requested in the blanks below.

Training Materials Kit for Prescriber* and Healthcare Facility

Kit includes:

- ZYPREXA RELPREVV Patient Care Program Instructions Brochure
- Reconstitution & Administration Poster & Training Video (DVD)
- Healthcare Professional Training Recorded Presentation (DVD) with Participant Guide
- PDSS Case Study Video (DVD)
- Medication Guide
- Prescribing Information

*Note: Patient Materials will automatically ship to a prescriber after prescriber registration is complete.

**Note: Patient Materials will automatically ship to a prescriber after prescriber registration is complete.*

**Training Material for Pharmacy Service Providers
(traditional pharmacy operation or buy & bill prescriber)**

ZYPREXA RELPREVV Patient Care Program Instructions Brochure

Training Materials Available as Individual Items

- ZYPREXA RELPREVV Patient Care Program Instructions Brochure
- Reconstitution & Administration Poster
- Reconstitution & Administration Training Video (DVD)
- Healthcare Professional Training Recorded Presentation (DVD) with participant guide
- PDSS Case Study Video (DVD)

Patient Materials

10 Wristbands

10 ID cards

Forms Available as Individual Items

- Single Patient Injection Form - tear-off pad of forms (25 forms/pad)
- Multiple Patient Injection Form - tear-off pad of forms (25 forms/pad)
- PDSS Form - 3 forms/pack
- Patient Registration Form - 5 patient forms/pack

You may also contact your Lilly sales representative to request materials and resources.

I understand that any personal information provided on this form will be used to provide educational materials only. For further privacy information please see the [Privacy Policy](#).

Submit

[PRIVACY POLICY](#)

[TERMS OF USE](#)

zyprexaRelprevv
(olanzapine) For Extended Release
Injectable Suspension

[Home](#) | [On-line Training](#) | [Registration Forms](#) | [Order Educational Materials](#) | [Prescribing Information](#) | [Medication Guide](#) |

Please see Prescribing Information for full details about the risks of ZYPREXA RELPREVV, including Boxed Warnings.

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ZYPREXA RELPREVV Patient Care Program

Prescribing Information

[Prescribing Information](#)

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ZYPREXA RELPREVV Patient Care Program

http://pi.lilly.com/us/zyprex pi.lilly.com

HIGHLIGHTS OF PRESCRIBING INFORMATION
 These highlights do not include all the information needed to use ZYPREXA RELPREVV safely and effectively. See full prescribing information for ZYPREXA RELPREVV.
 ZYPREXA RELPREVV (olanzapine) For Extended Release Injectable Suspension
 Initial U.S. Approval: 1996

WARNING: POST-INJECTION DELIRIUM/SEDATION SYNDROME AND INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS
 See full prescribing information for complete boxed warning.

- Patients are at risk for severe sedation (including coma) and/or delirium after each injection and must be observed for at least 3 hours in a registered facility with ready access to emergency response services. Because of this risk, ZYPREXA RELPREVV is available only through a restricted distribution program called ZYPREXA RELPREVV Patient Care Program and requires prescriber, healthcare facility, patient, and pharmacy enrollment. (2.1, 5.1, 5.2, 10.2, 17.2)
- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. ZYPREXA RELPREVV is not approved for the treatment of patients with dementia-related psychosis. (5.3, 5.16, 17.3)

RECENT MAJOR CHANGES

Warnings and Precautions:	
Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) (5.6)	10/2016
Falls (5.10)	01/2017

INDICATIONS AND USAGE

ZYPREXA[®] RELPREVV[™] is a long-acting atypical antipsychotic for intramuscular injection indicated for the treatment of schizophrenia. (1.1)

Efficacy was established in two clinical trials in patients with schizophrenia: one 8-week trial in adults and one maintenance trial in adults. (14.1)

DOSAGE AND ADMINISTRATION

150 mg/2 wks, 300 mg/4 wks, 210 mg/2 wks, 405 mg/4 wks, or 300 mg/2 wks. See Table 1 for dosing recommendations. (2.1)

ZYPREXA RELPREVV is intended for deep intramuscular gluteal injection only.

- Do not administer intravenously or subcutaneously. (2.1)
- Be aware that there are two ZYPREXA intramuscular formulations with different dosing schedules. ZYPREXA intramuscular (ZYPREXA RELPREVV) is a long-acting formulation and should not be used for acute treatment of schizophrenia. (2.1)

ADVERSE REACTIONS

Most common adverse reactions (≥5% in at least one of the treatment groups and greater than placebo) associated with ZYPREXA

- Suicide: The possibility of a suicide attempt is inherent in schizophrenia, and close supervision of high-risk patients should accompany drug therapy. (5.4)
- Neuroleptic Malignant Syndrome: Manage with immediate discontinuation and close monitoring. (5.5)
- Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS): Discontinue if DRESS is suspected. (5.6)
- Metabolic Changes: Atypical antipsychotic drugs have been associated with metabolic changes including hyperglycemia, dyslipidemia, and weight gain. (5.7)
 - Hyperglycemia and Diabetes Mellitus: In some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients taking olanzapine. Patients taking olanzapine should be monitored for symptoms of hyperglycemia and undergo fasting blood glucose testing at the beginning of, and periodically during, treatment. (5.7)
 - Dyslipidemia: Undesirable alterations in lipids have been observed. Appropriate clinical monitoring is recommended, including fasting blood lipid testing at the beginning of, and periodically during, treatment. (5.7)
 - Weight Gain: Potential consequences of weight gain should be considered. Patients should receive regular monitoring of weight. (5.7)
- Tardive Dyskinesia: Discontinue if clinically appropriate. (5.8)
- Orthostatic Hypotension: Orthostatic hypotension associated with dizziness, tachycardia, bradycardia and, in some patients, syncope, may occur especially during initial dose titration. Use caution in patients with cardiovascular disease, cerebrovascular disease, and those conditions that could affect hemodynamic responses. (5.9)
- Leukopenia, Neutropenia, and Agranulocytosis: Has been reported with antipsychotics, including ZYPREXA. Patients with a history of a clinically significant low white blood cell count (WBC) or drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of ZYPREXA RELPREVV should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors. (5.11)
- Seizures: Use cautiously in patients with a history of seizures or with conditions that potentially lower the seizure threshold. (5.13)
- Potential for Cognitive and Motor Impairment: Has potential to impair judgment, thinking, and motor skills. Use caution when operating machinery. (5.14)
- Hyperprolactinemia: May elevate prolactin levels. (5.17)
- Laboratory Tests: Monitor fasting blood glucose and lipid profiles at the beginning of, and periodically during, treatment. (5.18)

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orevv[™]
 Extended Release
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ZYPREXA RELPREVV Patient Care Program

Medication Guide

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ZYPREXA Relprevv
(olanzapine) For Extended Release
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http://pi.lilly.com/us/zyprex

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Medication Guide

ZYPREXA® RELPREVV™ (zy-PREX-a REL-prev)
(olanzapine)
For Extended Release Injectable Suspension

Read the Medication Guide that comes with ZYPREXA RELPREVV before you start taking it and each time before you get an injection. There may be new information. This Medication Guide does not take the place of talking to your doctor about your medical condition or treatment. Talk with your doctor if there is something you do not understand or you want to learn more about ZYPREXA RELPREVV.

What is the most important information I should know about ZYPREXA RELPREVV?
Before you receive ZYPREXA RELPREVV treatment you must:

- understand the risks and benefits of ZYPREXA RELPREVV treatment. Your doctor will talk to you about the risks and benefits of ZYPREXA RELPREVV treatment.
- register in the ZYPREXA RELPREVV Patient Care Program. You must agree to the rules of the ZYPREXA RELPREVV Patient Care Program before you register.

ZYPREXA RELPREVV may cause serious side effects, including:

1. Post-injection Delirium Sedation Syndrome (PDSS).
2. Increased risk of death in elderly people who are confused, have memory loss and have lost touch with reality (dementia-related psychosis).
3. High blood sugar (hyperglycemia).
4. High fat levels in your blood (increased cholesterol and triglycerides), especially in teenagers age 13 to 17.
5. Weight gain, especially in teenagers age 13 to 17.

These serious side effects are described below.

1. **Post-injection Delirium Sedation Syndrome (PDSS).** PDSS is a serious problem that can happen after you get a ZYPREXA RELPREVV injection if the medicine gets in your blood too fast. This problem usually happens within 3 hours after you receive ZYPREXA RELPREVV. If the medicine gets in your blood too fast, you may have some of the following symptoms:
 - feel more sleepy than usual
 - feel dizzy
 - feel confused or disoriented
 - trouble talking or walking
 - muscles feel stiff or shaking
 - feel weak
 - feel grouchy or angry
 - feel nervous or anxious

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In order to enroll in the ZYPREXA RELPREVV Patient Care Program, you must first complete the required training then submit the appropriate registration form.

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ZYPREXA RELPREVV Patient Care Program

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ZYPREXA RELPREVV PATIENT CARE PROGRAM CONTACT INFORMATION

ZYPREXA RELPREVV Patient Care Program

Phone: 1-877-772-9390

Fax: 1-877-772-9391

ZYPREXA RELPREVV Patient Care Program Coordinating Center Hours of Operation

Monday – Friday: 8am – 8pm ET

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Pharmacy Finder

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Search For

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Radius

- 1 mile
- 5 miles
- 10 miles
- 15 miles
- 20 miles
- 25 miles

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ZYPREXA RELPREVV Patient Care Program

Privacy Policy

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Scope

This Website Privacy Statement is provided by Lilly to all visitors ("you" or "your") who use the publicly available pages of the ZYPREXA RELPREVV Patient Care Program Website located at <https://www.zyprexarelprevvprogram.com/> (the "Site") and Authorized Users of the Patient Care Program Website. "Authorized Users" are eligible Prescribers, Healthcare Facilities and Pharmacy Service Providers. "Prescribers" include physicians, physician's assistants, nurse practitioners, and pharmacists. "Healthcare Facility" means a healthcare facility administering and/or monitoring injections of ZYPREXA RELPREVV. "Pharmacy Service Provider" means any retail pharmacy, hospital pharmacy, physician, or properly licensed healthcare facility that can order for and deliver ZYPREXA RELPREVV to a healthcare professional in accordance with their agreement to implement all relevant requirements of the ZYPREXA RELPREVV Patient Care Program. The "Patient Care Program Website" is an Authorized User-only portal available through the Site which enables Authorized Users to prescribe ZYPREXA RELPREVV.

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Information We Collect

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Information You Voluntarily Provide

You may visit most areas of this website without providing directly identifiable Personal Information or revealing your identity. However, in some cases you may choose to voluntarily provide Personal Information via this website in order to register for, or request, additional information or services, including obtaining access to the Patient care program website. In such cases, we will collect information that can identify you, such as your name, address, telephone, number, email address, and other similar information ("**Personal Information**").

Registration. Registration is optional; however, Authorized Users are provided access to the Patient Care Program Website and to information and online services not provided on the public website, as well as the ability to login to the Patient Care Program Website when revisiting the Site. The Personal Information you disclose to us during registration and in connection with the Patient Care Program Website is provided strictly on a voluntary basis. We may also collect Non-Personal Information during the registration process as described above. You may register on the Patient Care Program Website by filling out a form and submit it to us online or otherwise. You will need to provide certain Personal Information including first name, last name, and/or email address to register.

The type of access and services offered through the Patient Care Program Website may depend on whether you have registered as a Prescriber, a Healthcare Facility, or a Pharmacy Service Provider.

When you become an Authorized User, you may be asked to provide us with the Personal Information and/or Health Information of one or more patients with their consent, on whose behalf you are assisting in their care by a Healthcare Facility or a Pharmacy Service Provider, or patients that you are treating. After you login to the Patient care program website, you may be able to view certain Personal Information and Health Information of your patients, and use other services the Patient Care Program Website may offer. The term "**Health Information**" means any information, in any form, related to the past, present, or future health or medical status, condition, or treatment of a person, including, by way of example, but not limitation, names of doctors, health conditions, medicines, and/or prescription information and history.

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Changes to Our Privacy Practices

We may update this Privacy Statement from time to time. When we do update it, for your convenience, we will make the updated statement available on this page. We will always handle your Personal Information in accordance with the Privacy Statement in effect at the time it was collected. We will not make any materially different use your Personal Information unless we notify you and give you an opportunity to object.

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If you are receiving commercial emails from us you may write to the address below or follow the opt-out instructions on those emails.

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ZYPREXA RELPREVV Patient Care Program

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Purpose

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