SINGLE PATIENT INJECTION FORM

INJECTION

ZYPREXA Relprevv
(olanzapine) For Extended Release Injectable Suspension

IMPORTANT: Before administering the injection, confirm there will be someone to accompany the patient after the 3-hour observation period. If this cannot be confirmed, do not give the injection.

Submit this information within 7 days after the patient's injections. If you are aware that the patient's prescriber has changed, please notify the ZYPREXA RELPREVV Patient Care Program Coordinating Center.

Patient No.: (PIN) ☐☐☐☐☐☐

Injection Facility Name: _____

Patient Name: _____ _____ _____
First MI Last

Date of Birth: ☐☐-☐☐-☐☐☐☐
month day year

PDSS since the last visit? (After the patient left the office, following his/her previous injection, did the patient experience post-injection delirium/sedation syndrome?)

☐ No ☐ Yes

If Yes, has the prescriber been notified of the PDSS event?

☐ Yes ☐ No

ZYPREXA RELPREVV TREATMENT

Date of Injection: ☐☐-☐☐-☐☐☐☐
month day year

Time of ZYPREXA RELPREVV injection: ☐☐ : ☐☐
24-hour clock

Dose of Injection: ☐ 150 mg ☐ 210 mg ☐ 300 mg ☐ 405 mg ☐ Other dose _____ mg

Was the patient observed for at least 3 hours post-injection? ☐ Yes ☐ No

Did the patient experience post-injection delirium/sedation syndrome during the onsite post-injection observational period?

☐ No ☐ Yes

If Yes, has the prescriber been notified of the PDSS event? ☐ Yes ☐ No

Following the injection, was the patient alert, oriented, and absent of any signs and symptoms of PDSS prior to being released from the healthcare facility?

☐ Yes ☐ No

Following the injection, was the patient accompanied from the facility?

☐ Yes ☐ No ☐ Not applicable, patient did not leave facility (in-patient)

Was the patient or legal guardian given a Medication Guide prior to this injection? ☐ Yes ☐ No

_____ DATE: ☐☐-☐☐-☐☐☐☐
Healthcare Facility Staff Member Signature month day year

Healthcare Facility Staff Member Name (print): _____

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Reference ID: 4596482

Insert current US Prescribing Information, including the Medication Guide

PRESCRIBER REGISTRATION FORM

PRESCRIBER

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 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.
- 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: ☐☐ – ☐☐ – ☐☐☐☐

Prescriber Signature — month — day — year

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Reference ID: 4596482

PHARMACY REGISTRATION FORM

PHARMACY

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: _____

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

_____ Date: ☐☐ – ☐☐ – ☐☐☐☐

Pharmacist-in-Charge Signature month day year

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

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BUY & BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

BUY & BILL PHARMACY

ZYPREXA Relprevv™ (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:

- 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.

_____ Date: ☐☐ – ☐☐ – ☐☐☐☐
Administrator Signature — 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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HEALTHCARE FACILITY REGISTRATION FORM

ZYPREXA Relprevv™
(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: _____ (if different from above) Fax: _____ (if different from above)

Email: _____

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

Facility Name: _____

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

Email: _____

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

Facility Name: _____

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

Email: _____

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

Facility Name: _____

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

Email: _____

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

Facility Name: _____

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

Email: _____

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

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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 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: ☐☐ – ☐☐ – ☐☐☐☐
Authorized Healthcare Facility Representative Signature — 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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