

Instructions: This form is used to enroll a health care practitioner in the FazaClo Patient Registry. Submitting this completed form indicates you have read and agree to the Statement of OBLIGATIONS below. All forms must be signed and dated by the health care practitioner.

Health Care Practitioner Statement of OBLIGATIONS:

- ⌚ I have reviewed the FazaClo package insert and agree to participate in prescribing and monitoring only according to product labeling and only with a pharmacy/pharmacist enrolled in the FazaClo Patient Registry.
 - ⌚ I understand the risk of death associated with agranulocytosis and granulocytopenia when prescribing FazaClo and agree to register all applicable patients in the FazaClo Patient Registry to support early detection of WBC and ANC suppression and ensure that no patient is inappropriately rechallenged with a clozapine product.
 - ⌚ I agree to prescribe FazaClo only after verifying patient rechallenge status and an acceptable baseline WBC count ($\geq 3500/\text{mm}^3$) and ANC ($\geq 2000/\text{mm}^3$) test results and only after receiving a Patient Registration Number (PRN) from the FazaClo Patient Registry.*
 - ⌚ I agree to provide the FazaClo Patient Registry with all WBC count and ANC test results for all registered patients within:
 - o 7 days of blood draw for patients on weekly monitoring schedule*
 - o 14 days of blood draw for patients on an every-2-weeks monitoring schedule*
 - o 28 days of blood draw for patients on an every-4-weeks monitoring schedule*
 - ⌚ I agree to notify the FazaClo Patient Registry of all patients permanently discontinued on FazaClo and submit the required WBC count and ANC test results until they return to normal and for at least 4 weeks from day of discontinuation of therapy.
 - ⌚ I understand the FazaClo Patient Registry will verify rechallenge status against the Clozapine National Non-Rechallenge Masterfile and will update this list with all patients permanently discontinued on FazaClo due to an abnormal blood event as defined by product labeling.
 - ⌚ I understand the FazaClo Patient Registry will be internally audited and will monitor adherence to prescribing, monitoring, and timeliness requirements and will promptly notify registered health care practitioners and pharmacies of any discrepancies or missing information.
- *If the patient is being switched to FazaClo from another formulation of clozapine, FazaClo may be dispensed before a PRN is obtained. In this case, the PRN will be issued when the pharmacist reports the WBC count and ANC test results to the FPR.

Health Care Practitioner Acknowledgement:	Date: (MM/DD/YYYY)
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Health Care Practitioner Name (Please Print)

Last:	First:	M.I.	Suffix:
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Health Care Practitioner ID# (optional):

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Medical Facility Information (Please Print)

Facility Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	E-mail:

Please Answer the Following Question:

1. Are you currently enrolled in any other clozapine registry? Yes No

If yes, please indicate name of registry:

Please Mail or FAX Completed Form to:
FazaClo Patient Registry
 1818 Market Street, Suite 2350
 Philadelphia, PA 19103

Phone: 1-877-329-2256
FAX: 1-877-329-2259

*The blood work draw date may not be more than 7 days old in order for the pharmacist to dispense the drug, regardless of the patients' monitoring schedule