

## PHARMACY REGISTRATION FORM

**This form is used to register pharmacies into the Teva Clozapine Patient Registry.**

**Please respond to the following questions**

- Is Clozaril® currently dispensed from your pharmacy? Yes  No
- Is your pharmacy registered with the Clozaril National Registry? Yes  No

**Responsibilities of the Pharmacy/Pharmacist**

1. I have reviewed and understand the clozapine package insert.
2. I understand that death could occur as a result of agranulocytosis and that all patients on Teva clozapine should be registered with the Teva Clozapine Patient Registry to help reduce the risk of re-challenge in a patient with prior unacceptable WBC counts or ANC values as defined in the clozapine package insert.
3. I understand that the Teva Clozapine Patient Registry will verify a patient's rechallenge status with the National Non-Rechallenge Masterfile if the patient is new to clozapine, restarting clozapine or if experience with clozapine is unknown to the physician or pharmacist.
4. I understand that a current and acceptable WBC count and ANC value is required prior to dispensing clozapine as well as regular lab counts during treatment and for 4 weeks after discontinuing treatment.
5. I understand that WBC counts and ANC values should be reported to the Teva Clozapine Patient Registry within 7 days of the blood draw date.
6. I agree to notify the Teva Clozapine Patient Registry of any discontinued patients or adverse events.
7. I understand that the Teva Clozapine Patient Registry may contact the physician and/or pharmacist to resolve discrepancies or obtain information about the patient.

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Month/Day/Year

**Pharmacist Name (Print):** \_\_\_\_\_

**Pharmacy DEA/ID#:** \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_  
Month/Day/Year

**Pharmacy Name:** \_\_\_\_\_

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

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

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

**Mail or fax completed form to:**

Teva Clozapine Patient Registry  
50 NW 176<sup>th</sup> Street, Butler Building  
Miami, Florida 33169

Phone: 800/507-8334  
Fax: 800/507-8339

Email: [Clozapine.Registry@TevaUSA.com](mailto:Clozapine.Registry@TevaUSA.com)  
Website: [www.ClozapineRegistry.com](http://www.ClozapineRegistry.com)

Please provide contact information of your clozapine wholesaler.

**Wholesaler Information**

Name:

Company/Location:

Phone/Fax: