AA-Clozapine Patient Care Network - PATIENT REGISTRATION

Phone: 1-877-276-2569 / Fax: 1-866-836-6778 / Website: www.aaspire.ca

1165 Creditstone Rd., Unit 1, Vaughan, Ontario L4K 4N7

17-AA004_AAC0350E1

AA-CLOZAPINE ASSIGNED PIN:

FOR OFFICE USE ONLY

The Physician is responsible for registering the Patient in the AA-Clozapine Patient Care Network. Please check one:

☐ New Patient to AA-Clozapine ☐ Patient Restart ☐ Modify currently registered AA-Clozapine Patient ☐ Discontinuation

1 PATIENT REGISTRATION

Initials: ☐ First ☐ Middle ☐ Last

Date of birth: ____/____/____ DD MMM YYYY

Sex: ☐ M ☐ F ☐ Other: _____

Ethnicity: ☐ Caucasian ☐ Asian ☐ Black ☐ Other (specify): _____

Status: ☐ Inpatient ☐ Outpatient ☐ No interruption in treatment

Health Card #: _____

Monitoring Frequency: ☐ Weekly ☐ Biweekly ☐ Every Four Weeks

Disposition (if patient is discontinuing AA-Clozapine)

AA-Clozapine stop date: ____/____/____ DD MMM YYYY

Reason for discontinuation (please print): _____

Name: _____ PLEASE PRINT

Title: _____ PLEASE PRINT Signature: _____

2 PATIENT'S TREATMENT RESOURCE TEAM - PHARMACIST REGISTRATION

If Pharmacy previously registered, please indicate Pharmacy PIN, and sign: ☐☐☐☐☐☐

Pharmacist Name: _____

Pharmacist License #: ☐☐☐☐☐☐☐☐

Pharmacy Name: _____

Address: _____

Prov: ☐☐ Postal Code: ☐☐☐☐☐☐

City: _____

Tel: ☐☐☐-☐☐☐-☐☐☐☐ Ext: _____

Fax: ☐☐☐-☐☐☐-☐☐☐☐

Email: _____

If Website Login is requested: ☐ New User ☐ View only access ☐ Write and view access

I confirm that all dispensing pharmacists at this location will only dispense AA-Clozapine at the specified frequency upon confirmation that the patient has had his/her blood drawn for a Complete Blood Count and Differential for the current period.If applicable, I also confirm responsibility for all actions undertaken by the website login.

Date: ____/____/____ DD MMM YYYY Pharmacist's signature: _____

3 PATIENT'S TREATMENT RESOURCE TEAM - PHYSICIAN REGISTRATION

If Physician previously registered, please indicate Physician PIN, and sign: ☐☐☐☐☐☐

Physician Name: _____

Physician License #: ☐☐☐☐☐☐☐☐

Facility Name: _____

Address: _____

Prov: ☐☐ Postal Code: ☐☐☐☐☐☐

City: _____

Tel: ☐☐☐-☐☐☐-☐☐☐☐ Ext: _____

Fax: ☐☐☐-☐☐☐-☐☐☐☐

Email: _____

Statement by treating Physician

I, the treating physician, will ensure that blood testing (white blood cell count and differential) for this patient (identified below) as required by the AA-Clozapine Product Monograph is performed at the specified frequency. I understand that no pharmacy will dispense any brand of clozapine to my patient without my prior knowledge and permission regarding which brand is being dispensed. In this way I will be able to inform the laboratory to send my patient's results to the appropriate manufacturer's clozapine database (AA-Clozapine Patient Care Network). I will not prescribe AA-Clozapine until the non-rechallengeable status of this patient has been verified.

I have informed the patient and he/she has not objected to the release of relevant safety information held within a clozapine database to any other clozapine database of an approved manufacturer of clozapine in Canada, if needed for the safe utilization of this medication and/or for the continuous monitoring of the patient. The information which may be released, includes the non-rechallengeable/ hematological status of the patient, white blood cell counts and absolute neutrophil counts, dates and other information as may be relevant to the safe treatment of the patient with clozapine.

Date: ____/____/____ DD MMM YYYY

☐ ← By selecting this box, I authorize the laboratory to release to AA-Pharma (1-866-836-6778) all hematological CBC and differential lab results for this patient.

Physician signature: _____

4 PATIENT'S TREATMENT RESOURCE TEAM - LABORATORY AND COORDINATOR REGISTRATION

If laboratory previously registered, please indicate lab PIN: ☐☐☐☐☐☐

Laboratory Name: _____

Tel: ☐☐☐-☐☐☐-☐☐☐☐ Ext: _____

Fax: ☐☐☐-☐☐☐-☐☐☐☐

If Coordinator/Case Manager/Nurse Practitioner is previously registered, please indicate Coordinator's site PIN: ☐☐☐☐☐☐

Coordinator Name: _____

Office/Clinic Affiliated Institution/Ward: _____

Tel: ☐☐☐-☐☐☐-☐☐☐☐ Ext: _____

Fax: ☐☐☐-☐☐☐-☐☐☐☐

If Website Login is requested: ☐ New User ☐ View only access ☐ Write and view access

Coordinator's signature: _____

PLEASE NOTE: Please ensure AA Pharma is placed on the Standing Order/Requisition form so that we receive copies of the CBC results for the patient

TO COMPLETELY PROCESS NEW PATIENTS AND RESTARTS, HEMATOLOGICAL RESULTS WITHIN THE LAST 30 DAYS ARE REQUIRED

DISCLOSURE

a) I have reviewed and understand the AA-CLOZAPINE product monograph.
b) I understand that death can occur as a result of agranulocytosis with the use of AA-CLOZAPINE, and that all patients on AA-CLOZAPINE must be enrolled in the AA-CLOZAPINE Patient Care Network to help reduce the risk of a nonrechallengeable patient reusing AA-CLOZAPINE. I understand that patients placed on the nonrechallengeable list have had previous unacceptable WBC counts, and/or ANC values, and/or Clozapine induced myocarditis as defined in the AA-CLOZAPINE product monograph.
c) I understand that the patient's rechallengeable status will be verified prior to the initiation of treatment for all patients that are new to treatment, or for patients with an unknown or interrupted history on Clozapine.
(d) I, the Physician, will only prescribe AA-CLOZAPINE following the receipt of a PIN number from the AA-CLOZAPINE Patient Care Network.
(e) I agree to notify the AA-CLOZAPINE Patient Care Network of any discontinued patients or interruptions in AA-CLOZAPINE therapy.
(f) I, the Physician, will ensure that if the patient is female, she is not pregnant nor breastfeeding.
(g) I, the Pharmacist, will only dispense AA-CLOZAPINE following the receipt of a PIN number from the AA-CLOZAPINE Patient Care Network.
(h) I, the Physician agree to ensure that hematological testing is performed at the required frequency (as per the product monograph) and submit copies of all lab reports indicating WBC and ANC results to AA Pharma within 7 days.
(i) I agree to submit the four required weekly lab reports containing WBC and ANC counts after a patient discontinues Clozapine therapy.
(j) I understand that the AA-CLOZAPINE Patient Care Network will monitor compliance with reporting requirements and will notify the patient's physician and/or pharmacist of any discrepancies or overdue lab reports.
(k) In the event of agranulocytosis, clozapine induced myocarditis, or any other serious event, including any lack of drug effect and any clozapine related hospitalization I agree to fill out the required Serious Adverse Event form(s) and send this form(s) directly to AA-Clozapine Patient Care Network within 24 hours via fax to 18668366778 or report via phone to 18772762569.