Clozapine Patient Registry

IVAX

Clozapine Patient Assistance Program

To: Patient Assistance Program C/O IVAX Pharmaceuticals
Fax: 800-507-8339 Date: _____

CONFIDENTIAL

Title of individual completing this form: _____

Phone number: _____ **Upon completion of order process, this form will be faxed back with your confirmation #.**

Fax number: _____

- **Is Patient registered with IVAX clozapine patient registry?** ☐ Yes ☐ No
  - If yes, please provide IVAX Eligibility Code. _____
  - If no, please provide D.O.B. and monitoring frequency _____

or contact IVAX clozapine registry at **800-507-8334** to register the patient or visit www.**ClozapineRegistry.com**

☐ **New Patient.** Patient is new to clozapine therapy and we are requesting replacement of 12 weeks of product dispensed based o patient's dosage during the period.

☐ **Indigent Patient.** Patient financially unable to pay for medications.

☐ **Temporary.** Patient is awaiting Medicaid/insurance coverage.

Patient's Initials: _____ Eligibility Code: _____ Social Security No. _____

Daily Dosage: (indicate amount dispensed over initial 12 weeks)

		Qty per day/25mg	Qty per day/100mg
Total Daily dosage			
Unit dose	☐ Yes ☐ No		

Physician's Name: _____ DEA # _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip _____

Telephone: _____ Fax: _____

Pharmacist Name: _____

Pharmacy Name: _____ DEA # _____

Address: _____

City: _____ State: _____ Zip _____

Telephone: _____ Fax: _____

Signature: _____
Your signature certifies the above information is accurate and complete

TO BE COMPLETED BY IVAX **Confirmation #:** _____ **Renewal Date:** _____
Please refer to your IVAX Eligibility Code when inquiring about this patient.