# TEVA CLOZAPINE ASSISTANCE PROGRAM™

# ENROLLMENT APPLICATION

**All fields required - FAX completed form to: 253.218.0875**

If you have any questions regarding the Teva Clozapine Assistance Program, please call us at 800-292-4283

## Section 1: This section to be completed by Patient or Legal Guardian.

Patient's Name: *(First)* *(Last)* *(M.I.)* Date of Birth: / / *(MM)* *(DD)* *(YYYY)*

Address:

City: State: Zip Code:

Phone #: Social Security #: Gender: Male ☐ Female ☐

Are you a U.S. Resident? Yes ☐ No ☐ | Household size *(Number of persons who contribute to or are dependent on patient's household income)*:

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ | Employment Status: Employed ☐ Self-employed ☐ Retired ☐ Unemployed ☐

**Total Gross Monthly Household Income: (Include all income of persons who contribute to or are dependent on patient's household income)**

| | | |
|---|---|---|
| Salary/Wages: $ | Unemployment: $ | Veterans Benefits: $ |
| Social Security Retirement: $ | Alimony/Child Support: $ | Pension/Retirement: $ |
| Supplemental Security Income: $ | Rental Income: $ | Other: $ |
| Social Security Disability: $ | Workers Compensation: $ | TOTAL: $ |

**Insurance Information: Indicate if patient has prescription drug benefit for the requested Teva medication through any of the following insurers/payers/programs (Y = yes; N = no)**

| Insurer/Payer/Program | Rx Benefits (circle) | Insurer/Payer/Program | Rx Benefits (circle) | Insurer/Payer/Program | Rx Benefits (circle) |
|---|---|---|---|---|---|
| Medicare | Y N | Medicaid | Y N | Other: (List Insurer if "Y") | Y N |
| Private Insurance: (List Insurer if "Y") | Y N | VA Medical Benefits | Y N | None - Uninsured | Check if Applicable: ☐ |

I attest that the above information is correct and complete.

*Signature of patient or legal guardian:* *Date:*

## Section 2: This section to be completed by attending Physician.

Physician's Name: DEA #:

Physician's Address (No P.O. Box): *(First)* *(Last)*

City: State: Zip Code:

Phone #: FAX #: Email (optional):

Ship the Prescriptions to: | Rel: Patient ☐ Physician ☐ Clinic ☐ Family/Caregiver ☐

Shipping Address (No P.O. Box): *(Name first)* *(Last)*

City: State: Zip Code: Phone #:

Draw Frequency (WBC): weekly ☐ every 2 weeks ☐ every 4 weeks ☐ | Last draw date: month / day / year

Patient Allergies: No ☐ Yes ☐ If yes, specify:

Patient Diagnosis: | Preferred Lab Name/Phone:

**Clozapine Prescription Information: (Automatic enrollment is for 52 weeks, please prescribe the number of refills accordingly.)**

| Clozapine Tablets: | 25 mg ☐ | 50 mg ☐ | 100 mg ☐ | 200 mg ☐ |
|---|---|---|---|---|
| Dispense Quantity: | | | | |
| Directions: | | | | |
| # Refills (to last 52 weeks): | | | | |

I attest to the best of my knowledge that the information above is correct and the intended therapy is medically necessary for the patient listed above. I have no knowledge of any intent to sell, barter or give this product to any person other than the patient for whom it has been prescribed.

*Signature of physician:* *Date:*



**TO ENROLL, PLEASE COMPLETE THIS APPLICATION.**



***Applications must be accompanied by a signed Patient Authorization Release Disclosure of Medical Information Form and your most recent ANC results.*** *The eligibility requirements for acceptance into the Teva Clozapine Assistance Program are subject to change at any time, with or without prior notice. The Program reserves the right to disqualify any patient's participation in the Program if, in the sole discretion of the Program, that patient fails to meet the eligibility requirements then in effect.*

# AUTHORIZATION TO USE OR DISCLOSE

# HEALTH INFORMATION

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

## USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

*Persons/organizations authorized to use or disclose the information*: My insurer, pharmacist, physician or other health care provider.

*Persons/organizations authorized to receive the information*: Teva Pharmaceuticals USA, Inc. ("TEVA"), Genoa-QoL Healthcare Company ("GENOA") and other companies that TEVA uses to administer the TEVA Clozapine Assistance Program (the "Program").

*Purpose of requested use or disclosure*: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.

*This Authorization applies to the following information*: Information about my prescribed medications and medical condition, including prescriptions.

This Authorization may include disclosure of information relating to **mental health treatment** (except psychotherapy notes) only if I place my initials on the appropriate line below. I specifically authorize the release of such information to the persons listed above.

_____ **Mental Health Information**
(initial here)

## EXPIRATION

This Authorization expires three (3) years after I cease to participate in the Program.

## NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling 253.218.0870 and mailing a written revocation, signed by me or on my behalf, to an address that will be provided by the telephone representative. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of this Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization.

| _____ | _____ | _____ |
|---|---|---|
| ***Patient signature*** | ***Date*** | ***Relationship (if other than patient)*** |