Please complete this form using **BLACK INK** and **BLOCK LETTERS**

E >>> SHARED CARE DATA FORM

Zaponex Treatment Access System®

ZTAS®

This form is used to register a Shared Care situation for a patient with the Zaponex Treatment Access System (ZTAS®). Please complete all sections.

INCOMPLETE FORMS WILL NOT BE PROCESSED.

We will use the information provided on this form in accordance with the terms of the ZTAS Privacy Notice which is available from the ZTAS website www.ztas.co.uk.

Patient details

ZTAS PIN

Initials

Date of birth D D - M M - Y Y Y Y

Monitoring Frequency ☐ 4-week Start date Shared Care D D - M M - Y Y Y Y

Completed by Responsible Consultant Psychiatrist*

I, the responsible consultant*, acknowledge that the above patient has been on clozapine treatment for at least 52 consecutive weeks and has had no history of serious adverse events related to clozapine treatment. I confirm that treatment in a shared care setting is suitable for this patient.
I acknowledge that although treatment of this patient is in a shared care setting, I shall continue to be responsible for supervision of the patient's Zaponex® (clozapine) treatment. ∗ *Or other relevant specialist in the context of Zaponex® (clozapine) treatment indications, as per SPC.*

By signing, I confirm that the Shared Care Prescriber is informed of the Zaponex safety information and procedures, as explained in the Zaponex product information, ZTAS privacy notice and ZTAS manual.

Name S U R N A M E G M C

Date D D - M M - Y Y Y Y Signature

General practitioner / Shared Care prescriber

Title ☐ Prof ☐ Dr GMC number G M C

Name S U R N A M E Initials

Job title

Emergency telephone number*

Office / surgery number

∗ Phone number to be used by ZTAS staff, in case of an emergency with a patient.

Work email j o h n . s m i t h @ n h s . n e t

Please do not use group email address or gmail / yahoo etc.

Notification standard

ZTAS reminders, warnings and alerts will be sent to your work email address as above.
Registration of a group email address requires a Data Sharing Form to be completed and returned.

Contact Address

Medical Facility

Address

Town / city

Postcode

Please send this Form to ZTAS by email on **info@ztas.co.uk**

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Surname GP: SURNAME

Blood Testing

Routine Blood Samples Will be tested using: ☐ ZTAS Lab ☐ Local Lab ☐ POCT

Local Lab used, e.g. urgent samples: FACILITY NAME

Postcode

Local results must be analysed by a NEQAS (National External Quality Assurance Scheme) or equivalent certified laboratory, details of which must be registered with ZTAS.

Blood Sampling Location

Facility name

Contact person SURNAME Postcode

Telephone

Primary (Hospital) Pharmacy:

Pharmacy name

Postcode

Zaponex dispensed by another pharmacy in Homecare or dispensing arrangement? ☐ Yes* ☐ No

* If yes, please complete Homecare or dispensing pharmacy

Homecare or dispensing pharmacy

Pharmacy name

Postcode

Adverse event reporting

The ZTAS routinely monitors blood results for abnormalities in WBC, Neutrophils, Eosinophils and Platelets. Abnormalities in these parameters (i.e. where outside agreed ZTAS ranges) are reported as adverse events to the Leyden Delta Drug Safety department, who may then contact the responsible healthcare professional for further details. Upon review of your patient's health and blood results, if you consider any other abnormalities to the blood parameters (excluding those mentioned above) or if you signal abnormalities to physical or mental symptoms to be clinically significant, please ensure that you report these as adverse events. Reports of adverse events can be made to the MHRA directly via the Yellow Card scheme at www.mhra.gov.uk/yellowcard or the MHRA Yellow Card app. Adverse events should also be reported to Leyden Delta via info@ztas.co.uk or by calling 0207 3655 842.

DECLARATION

This document is my statement of intent to participate in the prescribing and monitoring of Zaponex® (clozapine) in association with the ZTAS. Signing of this form confirms my commitment to adhere to the Zaponex SPC and the ZTAS Manual. Signing of this form also constitutes confirmation of my understanding of, and commitment to, my responsibilities in respect of maintaining the confidentiality of my patient's details and reporting adverse events, as detailed above. I understand that my registration will be confirmed by a return email which has instructions for me to access the ZTAS system and that my details to access ZTAS should not be shared, in order to prevent unauthorised access to patient data. Should I no longer require access to the ZTAS, or if there are any changes to the patient data under my care, I will inform ZTAS of this within 30 days. I have read the ZTAS privacy notice and understand how my personal data will be used by Leyden Delta.

Prescribing reminders

- Zaponex may only be prescribed by a Consultant who is registered with the ZTAS, or other ZTAS-approved prescriber.
- Zaponex may only be prescribed for patients who are registered with the ZTAS.
- There must always be a current, valid blood result for the patient before any Zaponex is dispensed.

Name SURNAME GMC

Date DD-MM-YYYY Signature

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Please send this Form to ZTAS by email on **info@ztas.co.uk**