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

B >>> CONSULTANT PSYCHIATRIST DATA FORM

Zaponex Treatment Access System®

ZTAS®

This form is used to register as a Consultant, Associate Specialist or Specialty Doctor in the field of Psychiatry (or other relevant* therapeutic area) with the Zaponex Treatment Access System (ZTAS®). Please complete all sections. **INCOMPLETE FORMS WILL NOT BE PROCESSED.**

Consultant Psychiatrist* Details

* Or other specialist relevant in the context of Zaponex® (clozapine) treatment indications, as per SPC.

GMC number G M C

Title ☐ Prof ☐ Dr

Name SURNAME

Grade ☐ Consultant ☐ Associate Specialist ☐ Specialty Doctor

Specialty

Emergency telephone number

Office telephone number

Fax number

Email

Contact Address ☐ Hospital ☐ Private practice

Medical Facility

Address

Town/city

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. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Leyden Delta via info@ztas.co.uk or via telephone number 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 and confirms that I am an appropriate specialist for the supervision of Zaponex therapy. Signing of this form also constitutes a confirmation of my understanding of, and commitment to, my responsibilities regarding the reporting of adverse events, as detailed above. I understand that my registration will be confirmed by a return letter, enclosing my unique user ID and password to the ZTAS system and that these details 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.

Prescribing reminders

- Zaponex may only be prescribed by a consultant or physician who is registered with the ZTAS
- 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

Date d d - m m - y y y y

Signature

Please fax this form to ZTAS on 0207 3655843

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