F

>>> PROXY DATA FORM

Zaponex Treatment Access System®

ZTAS®

This form is used to register any person working in a medical facility or a pharmacy, needing access to the Zaponex Treatment Access System (ZTAS®) in order to fulfil tasks on behalf of one or more consultants or pharmacists registered with the ZTAS. This person is referred to by ZTAS as a 'proxy'. Proxies working at more than one location should submit a Proxy Data Form for each location. Please complete all sections. **INCOMPLETE FORMS WILL NOT BE PROCESSED.**

Type of registration ☐ Initial registration ☐ Registration at an additional location

Proxy Details

ZTAS user ID* ____________ * Only to be completed when already registered with ZTAS at a different location.

Title ☐ Mr ☐ Mrs ☐ Ms

Name F I R S T N A M E ____ S U R N A M E ____

Job title ____________

Telephone number ____________

Email ____________

Medical Facility/Pharmacy ____________

Address ____________

Town/city ____________ Postcode ____________

Adverse event reporting

Please note that Adverse Events should be reported. 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 by calling 0207 3655 842.

DECLARATION

This document is my statement of intent to participate in the dispensing 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 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 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
- Zaponex may only be dispensed under the responsibility of a ZTAS registered clozapine pharmacist.

Date d d - m m - y y y y Signature ____________

Authorisation by Clozapine pharmacist

I agree with the registration of the above pharmacy proxy. I acknowledge that I will at all times remain responsible for the tasks related to the treatment of patients with Zaponex® (clozapine) carried out by the above proxy for the pharmacy where I am the clozapine pharmacist.

Name S U R N A M E ____ GPC / PNI* ____

* Please circle appropriate. GPC = General Pharmaceutical Council. PNI = Pharmaceutical Society Northern Ireland.

Date d d - m m - y y y y Signature ____________

Please fax this form to ZTAS on 0207 3655843

PSS.F03.S04.002

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

F

>>> PROXY DATA FORM

Surname proxy: S U R N A M E

Authorisation by Consultant(s)

I agree with the registration of the proxy and acknowledge that I, as a consultant, will at all times remain responsible for the tasks related to the treatment of patients with Zaponex® (clozapine) carried out by the above proxy on my behalf.

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Name GMC

Date d d - m m - y y y y Signature CONSULTANT

Please fax this form to ZTAS on 0207 3655843

PSS.F03.S04.002