F >>> PROXY DATA FORM

Zaponex Treatment Access System®

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.** 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.

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 FIRSTNAME SURNAME

Job title

Telephone number

Work email

Medical Facility/Pharmacy

Address

Town/city Postcode

Adverse event reporting

Please note that adverse events should be reported. 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 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 for maintaining the confidentiality of ZTAS registered patients 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 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.
- Zaponex may only be dispensed under the responsibility of a ZTAS registered clozapine pharmacist.

Date d d - m m - y y y y Signature PROXY

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 in accordance with the ZTAS manual, which provides, amongst other things, that I am responsible for maintaining the confidentiality of the patients registered with above-named pharmacy and for the periodic review of the list of proxy users under my authorisation. I will inform ZTAS within 14 days if access to ZTAS and the ZTAS patient data is no longer required by any of the proxies registered under my authorisation, in order to prevent unauthorised access to patient data. By signing, I confirm that my Proxy is informed of the Zaponex safety information and procedures, as explained in the Zaponex product information, ZTAS privacy notice and ZTAS manual.

Name SURNAME GPC / PNI*

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

Date d d - m m - y y y y Signature CLOZAPINE PHARMACIST

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

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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 in accordance with the ZTAS manual, which provides, amongst other things, that I am responsible for maintaining the confidentiality of the patients registered in my association and for the periodic review of the list of proxy users under my authorisation. I will inform ZTAS within 14 days if access to ZTAS and the ZTAS patient data is no longer required by any of the proxies registered under my authorisation, in order to prevent unauthorised access to patient data.

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

Name

G M C

Date d d - m m - y y y y

Signature CONSULTANT

Name

G M C

Date d d - m m - y y y y

Signature CONSULTANT

Name

G M C

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Date d d - m m - y y y y

Signature CONSULTANT

Name

G M C

Date d d - m m - y y y y

Signature CONSULTANT

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

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