CARACO PHARMACEUTICAL LABORATORIES, LTD.	**Caraco Clozapine Distribution System (CCDS)** **FORM C: PHARMACY STOCKING FORM**	Internal Use **Pharmacy Stocking Code**	

Pharmacist: This Form is for registering Pharmacies who are already registered with another Clozapine monitoring program into CCDS for the purpose of stocking Caraco's Clozapine.
Fields marked with * are required for processing

Pharmacy and Physician have to get registered as a TEAM with CCDS within 7 days of dispensing Caraco Clozapine to Existing patients (patients who are on another manufacturer's Clozapine).

*Please place an "**X**" in the appropriate box:

1. I am currently enrolled in another manufacturer's Clozapine Distribution system. Yes ☐ No ☐
2. I am currently dispensing Clozaril ® (or another Clozapine). Yes ☐ No ☐

- By completing this form, I confirm that I am currently enrolled in a Clozapine Distribution System and have patients who are currently receiving this therapy.
- I am aware of the risks involved with Clozapine therapy and understand that Clozapine has been associated with agranulocytosis, which can be fatal.
- I also understand that Clozapine cannot be given to a new patient prior to registration and that this option is not available to new patients. I understand that 1 week's supply of Clozapine can be given to a patient already undergoing Clozapine therapy prior to TEAM and patient registration. I hereby commit to completing the registration requirements prior to the next weeks supply of Caraco Clozapine.
- I agree to closely monitor the blood counts of the patients and report any abnormalities to CCDS. I also agree to promptly submit the blood reports within seven days of blood draw, within 14 days for patients monitored bi-weekly or 28 days for patients monitored monthly and report any discontinuations to CCDS.
- I understand the importance of monitoring the blood counts weekly upto 4 weeks after discontinuation, and I hereby agree to do so.

Completion and signing of this form demonstrates my intention to participate in the CCDS and constitutes my commitment to dispensing of Clozapine upon receipt of acceptable WBC and differential counts in compliance with CCDS.

_____ _____
* Signature of Pharmacist Date (mm/dd/yy)

PHARMACIST

***Pharmacy Name** _____

***DEA/ID#:** ☐☐ ☐☐☐☐☐☐☐

*Name: _____
Last First Middle

Title _____

***Pharmacy Address:** _____

_____

***City** _____ ***State**_____ ***ZIP code** _____

***Tel:** (_____)_____

***Fax:** (_____)_____

E-mail Id: _____

WHOLESALER DETAILS

*Name of Wholesaler/Division_____

_____

*Address: _____

_____

*City _____ *State_____ *ZIP code _____

*Tel: (_____)_____

*Fax (_____)_____

On issuing the Pharmacy Stocking Code, appropriate members of the distribution channel will be informed about the Pharmacy's CCDS registration for purchase of Caraco's Clozapine

Mail Form to : CCDS, Caraco Pharmaceutical Laboratories Ltd., 1150 Elijah McCoy Drive, Detroit, MI 48202.
Toll Free Fax: 1-800-980-CCDS (2237) **Toll Free Tel : 1-888-Tel-CCDS (835-2237)**
Website : www.caracoclozapine.com

Clozaril ® is the registered Trademark of Novartis Pharmaceuticals Corporation
Form # 377, Rev 03/08 Previous edition is obsolete.