

BUY & BILL* PHARMACY SERVICE PROVIDER REGISTRATION FORM

BUY & BILL PHARMACY



To be enrolled in the ZYPREXA RELPREVV Patient Care Program, complete and fax this form to 1-877-772-9391. Training must be completed before a pharmacy service provider may be enrolled in the ZYPREXA RELPREVV Patient Care Program.

PHARMACY SERVICE PROVIDER INFORMATION

Enrollment Reenrollment Facility Name: DEA Number: Please specify description of Pharmacy: Community/Retail Specialty Pharmacy Hospital or Institution Other Address Line 1: Address Line 2: City: State: Zip Primary Phone: Secondary Phone: Fax:

SHIP TO INFORMATION

Ship To Address (if the same as above check here) Ship To Contact Name: Address Line 1: Address Line 2: City: State: Zip Primary Phone: Secondary Phone: Fax:

ADMINISTRATOR INFORMATION

First Name: MI: Last Name: Preferred Method of Communication: Email Fax Email: Phone: Fax: (if different from above)

PHARMACY SERVICE PROVIDER AGREEMENT

- By signing below, I acknowledge that: I have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure. I will ensure that all appropriate pharmacy staff are trained and have read and understand the ZYPREXA RELPREVV Patient Care Program Instructions Brochure. I will ensure that all appropriate pharmacy staff understand that ZYPREXA RELPREVV can only be dispensed for use in certain health care settings (e.g., hospitals, clinics) that have ready access to emergency response services and that can allow for continuous patient monitoring for at least 3 hours post-injection. I will ensure that pharmacy staff will verify that the patient is enrolled in the ZYPREXA RELPREVV Patient Care Program registry prior to dispensing each prescription/refill by accessing the system. I will ensure that pharmacy staff will not dispense ZYPREXA RELPREVV directly to patients. I will ensure pharmacy staff report the date of each ZYPREXA RELPREVV dispensing to the ZYPREXA RELPREVV Patient Care Program. I understand that the ZYPREXA RELPREVV Patient Care Program Coordinating Center may contact the pharmacy to clarify information provided or to obtain information about the patient.

I may cancel this registration by notifying the ZYPREXA RELPREVV Patient Care Program Coordinating Center by fax at 1-877-772-9391 or by phone at 1-877-772-9390. If I cancel, Lilly will cease to supply ZYPREXA RELPREVV to the facility.

Date: month - day - year Administrator Signature

* Buy & Bill Pharmacy Service Provider - a licensed healthcare provider that purchases pharmaceuticals through a licensed distributor for its own use in the treatment of a patient and then includes the cost of the pharmaceutical in its billing of patients and third-party payers.

PHONE 1 877 772 9390 FAX 1 877 772 9391 www.zyprexarelprevvprogram.com

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