CSAN®
®CLOZARIL® (clozapine) SUPPORT AND ASSISTANCE NETWORK

FORM

◯ Enrolment ◯ Modification ◯ Discontinuation
◯ Transfer / Discharge from hospital

TEL: 1-800-267-2726 **FAX:** 1-800-465-1312
BC ONLY, FAX TO: 1-604-689-1262

*To facilitate the safe use and continued monitoring of all patients taking clozapine, please ensure CSAN® (Fax 1-800-465-1312) is copied on all lab requisitions for a standing CBC with differential.

SECTION 1. Patient Information

◯ New start
◯ Restart

Indicate previous CSAN® number if known: | | | | | | | | | | |

For continuing treatment from another registry On clozapine since: Y Y M M D D

Patient's Initials: _____ _____ _____ Frequency: ◯ 7 ◯ 14 ◯ 28
First name or initial | Last name or initial | **Provincial HC# / File# / EPIC ID** (required for automatic result transfer)

Date of Birth: Y Y M M D D Sex at Birth: ◯ M ◯ F ☐ Self-identify as: _____ Status: ◯ Inpatient ◯ Outpatient

Race: ◯ Caucasian ◯ Black ◯ Asian ◯ First Nations ◯ Other (specify): _____ Copay # _____

BASELINE CBC & DIFF. VALUES: Sample Date: Y Y M M D D Leukocytes (WBC) (Optional) _____ X 10^9/L Neutrophils (ANC) _____ X 10^9/L

SECTION 2. Institution/Laboratory/Primary Contact

Institution: _____ Affiliated: _____

Address: _____ Tel.: _____ Ext.: _____

City: _____ Prov.: _____ Postal Code: _____ Fax: _____

Laboratory: _____

Tel.: _____ Fax: _____

Local Case Coordinator/Case Manager/Primary Contact

Name: _____ Tel.: _____ Ext.: _____

Email: _____ Fax: _____

SECTION 3. To register the pharmacy. To be completed and signed by Chief Pharmacist or Delegate Pharmacist

Pharmacist: _____ Pharmacist License No.: _____

Pharmacy Name: _____ Tel.: _____ Ext.: _____

Address: _____ Fax: _____

City: _____ Prov.: _____ Postal Code: _____ Email: _____

The pharmacist agrees to dispense CLOZARIL® on a weekly, every-two week or every-four-week basis upon confirmation of a blood test for the current period. The switching of a patient from one brand of clozapine to another must not be done by a pharmacist unless he/she obtains a new, registry-specific patient registration form filled out by the prescribing physician.[1]

_____ Y Y M M D D
Pharmacist Signature Date

SECTION 4. To register the prescriber. To be completed and signed by the Prescriber

I, the prescriber, will ensure that blood testing (white blood cell count and differential) for this patient (identified above) as required by the PrCLOZARIL® (clozapine) Product Monograph is performed at the specified frequency. I understand that no pharmacy will dispense any other brand of clozapine other than CLOZARIL® to my patient without my prior knowledge and permission regarding which brand is being dispensed. In this way I will be able to inform the laboratory to send my patient's results to the appropriate manufacturer's clozapine database CSAN®. I will not prescribe CLOZARIL® until the non-rechallengeable status of this patient has been verified.[1]

I have informed the patient and they have not objected to the disclosure or exchange of relevant personal information, including medical information, to and with CSAN® from sources of such information including laboratories, other clozapine databases, and health care providers as reasonably needed for the safe utilization of this medication and/or for the continuous monitoring of the patient by CSAN®. The information which may be disclosed and exchanged includes, the non-rechallengeable/hematological status of the patient, white blood cell counts and absolute neutrophil counts, dates and other information relevant to the safe treatment of the patient with CLOZARIL®.[1] I confirm that I have appropriately informed the patient about the purpose and content of the CSAN® monitoring service and obtained the consent of the patient for the collection, use, disclosure and exchange of the patient's personal information described above. I have also informed the patient that this consent relating to personal information will remain in effect for as long as the patient is in the CSAN® program, and for a reasonable time after the patient discontinues treatment with CLOZARIL® for administration purposes.

Prescriber Name: _____ Prov. License No.: _____

Address: _____ Tel.: _____ Ext.: _____

City: _____ Prov.: _____ Postal Code: _____ Fax: _____

Email: _____

_____ Y Y M M D D
Prescriber Signature Date

SECTION 5. Treatment Discontinuation - CLOZARIL® treatment was discontinued mainly due to:

◯ Non-compliance ◯ With blood testing ◯ With medication ◯ Both

◯ Other (specify): _____ Tel.: _____ Ext.: _____

_____ Y Y M M D D
Completed by Date of discontinuation

Reference: 1. CLOZARIL® Product Monograph. HLS Therapeutics Inc. July 10, 2025.

CA-CL-00158-EN

REVIEWED BY PAAB