Current as of 6/1/2013. This document may not be part of the latest approved REMS.

## Versacloz Patient Registry — WBC Count and ANC Monitoring Form

**Instructions:** This form is used to submit WBC count and ANC monitoring information according to the Versacloz Patient Registry protocol and package insert. Multiple dates of information may be logged on one form for one patient if data submission is via fax. In this case, complete log and resubmit form every time according to schedule. Multiple forms will be required if data submission is via mail. NOTE: FORM MUST BE SUBMITTED TO REGISTRY AT EVERY DISPENSATION TIME.

- The patient's Affiliated Healthcare Provider must complete this form after verifying the patient's required blood counts are within normal limits and timeframe according to Versacloz product labeling and healthcare provider evaluates patient.
- The Affiliated Healthcare Provider must provide Affiliated Pharmacist with completed WBC Count and ANC Monitoring Form and valid prescription for each dispensation of Versacloz to meet monitoring requirements.
- The Affiliated Pharmacist can dispense Versacloz ONLY after receiving a completed WBC Count and ANC Monitoring Form with valid PRN, a valid prescription, and verifying the WBC count and ANC test results are within normal limits and timeframe according to Versacloz package insert.

**A. Patient Information:**

**Initials: (F/M/L** ☐☐☐

**Patient Registration Number (PRN):** ☐☐☐☐☐

**Patient SSN:** ☐☐☐ – ☐☐ – ☐☐☐☐

**B. Affiliated Pair Information (Patient's Affiliated Treatment Pair):**

**Healthcare Provider DEA or ID#:** ☐☐ – ☐☐☐☐☐☐☐

**Pharmacy DEA or ID#:** ☐☐ – ☐☐☐☐☐☐☐

**C. WBC Count, ANC, and Treatment Dispensation Information:**

| Blood Draw Date (MM/DD/YYYY) | Total WBC Count (per mm$^3$) | ANC (per mm$^3$) | Treatment Status After Today's Evaluation C=Continue T=TEMP Discontinue P=PERM Discontinue | Medication Dispense Date (MM/DD/YYYY) | Total Daily Dose (mg/day) | Acceptable to Dispense Treatment? Y = Yes N = No | Monitoring Schedule After Today's Evaluation | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Weekly | Every Two Weeks | Every Four Weeks |
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| **Patient Notes** | | | | | | | | | |
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**Pharmacist: Once this form is received from the Affiliated Healthcare Provider this completed form should be mailed or FAXed to the**

**Versacloz Patient Registry**
**1818 Market Street, Suite 2350**
**Philadelphia, PA 19103**
**FAX: 1-877-798-0229**

**Alternatively, the data may be phoned into the Versacloz Patient Registry at 1-877-329-2256, or the information may be entered into the Versacloz database via the Internet at www.versaclozregistry.com**