ADASUVE® REMS Program
HEALTHCARE SETTING ENROLLMENT FORM

adasuve (loxapine) inhalation powder

To become certified in the ADASUVE REMS Program, review the Education Program for Healthcare Settings, complete this enrollment form and do one of the following:

Fax 855-755-0493 (Fax both pages) or Scan and e-mail to Enrollment@AdasuveREMSProgram.com Submit online at www.adasuverems.com/enrollment

HEALTHCARE SETTING INFORMATION

*indicates required field

Healthcare Setting Name*: _____

Setting DEA or* NPI Number: _____

Setting Type*: ☐ Medical Hospital ☐ Psychiatric Hospital ☐ Other (describe): _____

Setting Address*: _____

City*: _____ State*: _____ Zip*: _____

Phone*: _____ Fax*: _____

AUTHORIZED HEALTHCARE SETTING REPRESENTATIVE INFORMATION

First Name*: _____ Last Name*: _____

Position / Title*: _____

Phone*: _____ Fax*: _____

Email*: _____ _____

Preferred communication method*: ☐ Email ☐ Fax

HEALTHCARE SETTING ATTESTATIONS

As an authorized representative for the healthcare setting:

- I have reviewed the **Education Program for Healthcare Settings.**
- I must establish processes and procedures to:
  - assess the patient for respiratory abnormalities before administration (by medical and medication history, and chest auscultation),
  - monitor the patient for a minimum of 1 hour after administration for bronchospasm,
- My healthcare setting has immediate access to supplies and personnel onsite competent in the management of acute bronchospasm including: a short-acting bronchodilator (e.g., albuterol), delivered by inhaler (with spacer) or nebulizer and access to emergency assistance for symptoms that require immediate medical attention.

On behalf of the healthcare setting, we must comply with the following REMS requirements:

Before administering:

- Assess the patient's health status for a current diagnosis or history of asthma, chronic obstructive pulmonary disease (COPD) and other lung diseases associated with bronchospasm, acute respiratory signs and symptoms (e.g. wheezing), and current use of medications to treat airway disease such as asthma or COPD.
- Assess the patient's health status for respiratory abnormalities by chest auscultation.

After administering, for a minimum of 1 hour:

- Assess the patient's health status for signs and symptoms of bronchospasm.

During treatment, within a 24-hour period:

- Dispense no more than a single dose per patient.

At all times:

- Not dispense ADASUVE for use outside the certified healthcare setting.
- Report any adverse events of bronchospasm that occur following ADASUVE treatment to the ADASUVE REMS.
- Not distribute, transfer loan or sell ADASUVE. Maintain appropriate documentation that all processes and procedures are in place and being followed.
- Comply with audits by Alexza Pharmaceuticals, Inc., or a third party acting on behalf of Alexza Pharmaceuticals, Inc. to ensure that all processes and procedures are in place and are being followed.

To maintain certification to dispense:

- Have any new Authorized Representative enroll in the ADASUVE REMS by completing the **Healthcare Setting Enrollment Form** and submitting to the ADASUVE REMS.

I confirm that the information above is correct. I understand that this information will be used to document healthcare facilities that are eligible to receive ADASUVE. I also understand that this information may be shared with government agencies.

Authorized Healthcare Setting Representative **Signature**	Date
Authorized Healthcare Setting Representative (**Print**)	Title

Use this page to add each additional healthcare setting location for which the same **Authorized Representative** will be responsible:

ADDITIONAL HEALTHCARE SETTING INFORMATION

*indicates required field

Healthcare Setting Name*: ______________________

Facility DEA or* NPI Number: ______________________

Setting Type*: ☐ Medical Hospital ☐ Psychiatric Hospital ☐ Other (describe): ____________

Setting Address*: ______________________

City*: ____________ State*: ________ Zip*: ________

Phone*: ____________ Fax*: ____________

Healthcare Setting Name*: ______________________

Facility DEA or* NPI Number: ______________________

Setting Type*: ☐ Medical Hospital ☐ Psychiatric Hospital ☐ Other (describe): ____________

Setting Address*: ______________________

City*: ____________ State*: ________ Zip*: ________

Phone*: ____________ Fax*: ____________

Healthcare Setting Name*: ______________________

Facility DEA or* NPI Number: ______________________

Setting Type*: ☐ Medical Hospital ☐ Psychiatric Hospital ☐ Other (describe): ____________

Setting Address*: ______________________

City*: ____________ State*: ________ Zip*: ________

Phone*: ____________ Fax*: ____________

Healthcare Setting Name*: ______________________

Facility DEA or NPI Number*: ______________________

Setting Type*: ☐ Medical Hospital ☐ Psychiatric Hospital ☐ Other (describe): ____________

Setting Address*: ______________________

City*: ____________ State*: ________ Zip*: ________

Phone*: ____________ Fax*: ____________