

Clozaril® and red alert management

The information in this document is not intended as a definitive treatment strategy, but as a suggested approach for clinicians. It is based on previous successful experience. Each case should, of course, be considered individually.

This information is provided for healthcare professionals and should not be used as a patient information leaflet.

Background

The most commonly known side effects of clozapine are neutropenia and agranulocytosis. Neutropenia is defined (as per the Summary of Product Characteristics (SmPC) for Clozaril® (Clozapine)^{1,2}) as a neutrophil count of less than $1.5 \times 10^9/L$. Agranulocytosis is generally agreed and defined as a neutrophil count of less than $0.5 \times 10^9/L$ ³. Leukopenia (a reduction in the number of white blood cells (WBC)) without neutropenia may also occur.

The SmPC for Clozaril® goes on to state that:

Leukopenia and neutropenia are common ($\geq 1/100$ but $< 1/10$) reactions to Clozaril®. Agranulocytosis is an uncommon ($\geq 1/1,000$ but $< 1/100$) reaction.

A study by Munro *et al* (1999), found that of 12,760 patients treated with Clozaril®, the incidence of agranulocytosis was 0.73% and neutropenia was 2.7%.³

Neutropenia and agranulocytosis are usually reversible on cessation of clozapine but agranulocytosis may result in sepsis and can be fatal.^{1,2} When a monitoring service is not used, evidence suggests a mortality rate from agranulocytosis of 0.3%.^{1,2} This is compared to a mortality rate of 0.01% if used in conjunction with the CPMS.^{1,2}

Mechanism of clozapine-induced neutropenia/agranulocytosis

The mechanism of clozapine-induced neutropenia and agranulocytosis has not been established^{5,6} although several mechanisms have been proposed. It is likely that different mechanisms are involved for mild-to-moderate neutropenia (absolute neutrophil count $0.5-1.5 \times 10^9/L$) and agranulocytosis.⁷

Risk factors

The peak risk period for neutropenia and agranulocytosis is between weeks 6-18 and the risk decreases after the first year of treatment. Approximately 70% of agranulocytosis cases occur within the first 18 weeks of treatment.^{1,2}

Both neutropenia and agranulocytosis are idiosyncratic reactions and are not dose-related.^{4,5}

Since the mechanism of clozapine-induced agranulocytosis is not fully understood, it is difficult to predict whether factors such as other medications could increase the risk. However, there are case reports of patients receiving carbamazepine and clozapine concurrently who developed agranulocytosis.^{8,9}

Also, many patients who develop clozapine-induced agranulocytosis are receiving concomitant medication, often with drugs that are known to cause agranulocytosis themselves.¹⁰ Hence, clozapine should not be used with other drugs that are known to depress bone marrow function as these could increase the risk of a patient on clozapine developing neutropenia or agranulocytosis.^{1,2}

Long-acting depot antipsychotics should not be used with clozapine as they have the potential to depress bone marrow function and cannot be removed from the body in the event of neutropenia or agranulocytosis.^{1,2}

Management of a red alert

If a patient's WBC is less than $3.0 \times 10^9/L$ and/or the neutrophil count is less than $1.5 \times 10^9/L$ this is known as a **RED ALERT** and the following action must be taken:

- **STOP CLOZARIL[®] TREATMENT IMMEDIATELY**

- Check the patient for any signs of infection and contact the CPMS as soon as possible
- Arrange to take follow-up blood samples on the 2 days following the date of the red alert sample. If either of these follow-up blood counts is in the red alert range then the red alert is confirmed and Clozaril[®] is contraindicated
- If the red alert is confirmed **THE PATIENT MUST NOT RESTART CLOZARIL[®] TREATMENT**
- Full blood counts with differential should be performed **DAILY** whilst the blood counts remain in the red range, and the patient must be observed closely for signs of infection, such as a sore throat or fever
- Blood results should be reported to the CPMS as soon as they are available
- If antipsychotic medication is considered essential use a drug with a low potential to cause neutropenia and avoid depot preparations
- Review all other medication. Consider stopping any drugs which may reduce the WBC and/or neutrophil counts. If necessary introduce a more appropriate alternative

If the patient's neutrophil count falls to less than $1.0 \times 10^9/L$ or the WBC falls to less than $2.0 \times 10^9/L$ or if the patient develops a fever it is extremely important to contact a haematologist, or failing this, a general medical physician, for advice regarding appropriate treatment for the patient. This may include transferring the patient to a ward with facilities for the care of neutropenic patients.

Clozapine rechallenge is contraindicated in any patients who have experienced a red alert. All patients with a confirmed red result will be entered onto the Central Non-Rechallenge Database (CNRD UK) to ensure that they are not inadvertently re-exposed to clozapine from alternative suppliers.

Prescribers are encouraged to keep a record of all patients' blood results and to take any steps necessary to prevent the patient being rechallenged in error in the future.

Effect of sudden discontinuation of Clozaril[®]

When a patient has a red alert it is essential to stop clozapine immediately. Careful psychiatric monitoring of the patient is essential since symptoms may recur quickly.

Stopping clozapine suddenly can lead to physical and mental withdrawal effects which may occur within 2-3 days and usually within the first 2 weeks.¹¹ Patients may experience a rapid deterioration in their mental state with rebound psychosis.¹² In addition, abrupt withdrawal of clozapine has been associated with symptoms such as nausea, vomiting, diarrhoea, headache, restlessness, agitation and sweating¹¹ and it has been suggested that these are a result of cholinergic rebound since clozapine has strong anticholinergic action.¹² Discontinuation of clozapine for reasons other than a red alert, or other serious side-effect, should be done gradually to minimise the risk of withdrawal effects.

Red alert confirmation procedure

The SmPC for Clozaril® states: Immediate discontinuation of Clozaril® treatment is mandatory if either the WBC count is less than $3.0 \times 10^9/L$ or the ANC is less than $1.5 \times 10^9/L$ during Clozaril® treatment. WBC counts and differential blood counts should then be performed daily and patients should be carefully monitored for flu-like symptoms or other symptoms suggestive of infection. Confirmation of the haematological values is recommended by performing two blood counts on two consecutive days; however, Clozaril® should be discontinued after the first blood count.^{1,2}

The red alert is **confirmed** if one of the follow-up blood results is in the red range, after which follow-up samples are taken until the count recovers.

If neither follow-up sample is red then the red alert is **unconfirmed** and the patient may resume Clozaril® treatment. This may be at the normal dose if the break in treatment is less than two days or with retitration from 12.5mg if greater than two days. **The patient must remain off Clozaril® until the second follow-up result is obtained.**

Following an **unconfirmed** red alert, additional monitoring is needed as a precaution if the follow-up results are either amber or green, but still low for that patient, whether Clozaril® is restarted or not.

References

1. Clozaril Summary of Product Characteristics (online). Mylan Products Limited. <<http://www.medicines.org.uk/emc/>> (Accessed on 08/04/2020).
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6. Mendelowitz AJ *et al.* Clozapine-Induced Agranulocytosis. Risk Factors, Monitoring and Management. *CNS Drugs* 1995; **4**: 412-21.
7. Gerson SL. Clozapine – Deciphering the Risks. *New England Journal of Medicine* 1993; **329**: 204-205.
8. Gerson SL *et al.* Polypharmacy in Fatal Clozapine-Associated Agranulocytosis. *Lancet* 1991; **338**: 262.
9. Junghan U, Albers M and Woggon B. Increased Risk of Haematological Side-Effects in Psychiatric Patients Treated with Clozapine and Carbamazepine. *Pharmacopsychiatry* 1993; **26**: 262.
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12. Shiovtz TM *et al.* Cholinergic Rebound and Rapid Onset Psychosis Following Abrupt Clozapine Withdrawal. *Schizophr Bull* 1996; **22**: 591-5.

PRESCRIBING INFORMATION**CLOZARIL 25 mg Tablets****CLOZARIL 100 mg Tablets**

Please see Summary of Product Characteristics (SmPC) for full information before prescribing Clozaril.

The use of Clozaril is restricted to patients, physicians and nominated pharmacists registered with the Clozaril Patient Monitoring Service (CPMS).

In the UK a white cell count with differential count must be monitored:

- At least weekly for the first 18 weeks of treatment
- At least at 2-week intervals between weeks 18 and 52
- After 1 year of treatment with stable neutrophil counts, patients may be monitored at least at 4 week intervals

Monitoring must continue throughout treatment and for at least 4 weeks after discontinuation.

Blood clozapine level monitoring is advised in situations such as a patient ceases smoking or switches to e-cigarettes, when concomitant medicines may interact to increase clozapine blood levels, where poor clozapine metabolism is suspected, when a patient has pneumonia or other serious infection and in the event of onset of symptoms suggestive of toxicity.

Clozaril is associated with an increased risk of myocarditis and cardiomyopathy. If suspected Clozaril must be stopped immediately and the patient referred to a cardiologist and not re-exposed to Clozaril.

Presentations

Clozaril 25 mg Tablets containing 25 mg clozapine. Clozaril 100 mg Tablets containing 100 mg clozapine.

Indications

Treatment-resistant schizophrenic patients and in schizophrenia patients with severe, untreatable neurological adverse reactions to other antipsychotic agents, including an atypical antipsychotic agent prescribed for adequate duration. Psychotic disorders occurring during the course of Parkinson's disease, where standard treatment has failed.

Dosage and AdministrationTreatment-resistant schizophrenic patients

12.5 mg once or twice on the first day, followed by 25 mg tablets once or twice on the second day. Increase dose slowly, by increments (see SmPC). In most patients, antipsychotic efficacy can be expected with 200 to 450 mg/day given in divided doses. If dose does not exceed 200 mg/day, it can be given as a single administration in the evening. Once control is achieved, a lower maintenance dose may be effective. Treatment should be maintained for at least 6 months. Doses up to 900 mg/day can be used but the possibility of increased adverse reactions (especially seizures) occurring at doses over 450 mg/day must be considered.

See SmPC for details on re-starting therapy, ending treatment or switching from another antipsychotic.

Psychotic disorders occurring during the course of Parkinson's disease in cases where standard treatment has failed

The starting dose must not exceed 12.5 mg/day taken in the evening. Increase dose by 12.5 mg increments, with a maximum of two increments a week up to a maximum of 50 mg, preferably given as a single dose in the evening. The mean effective dose is usually between 25 and 37.5 mg/day.

The maximum dose of 100 mg/day must never be exceeded. Dose increases should be limited or deferred if orthostatic hypotension, excessive sedation or confusion occurs. Blood pressure should be monitored during the first weeks of treatment. When there has been complete remission of psychotic symptoms for at least two weeks, an increase in anti-parkinsonian medication is possible on the basis of motor status. Cautious titration and a divided dosage schedule are necessary to minimise the risks of hypotension, seizure and sedation.

Method of administration Clozaril is administered orally.

Switching from a previous antipsychotic therapy to Clozaril

It is generally recommended that Clozaril should not be used in combination with other antipsychotics. When Clozaril therapy is to be initiated in a patient undergoing oral antipsychotic therapy, it is recommended that the other antipsychotic should first be discontinued by tapering the dosage downwards.

Special populations: Hepatic impairment Patients with hepatic impairment should receive Clozaril with caution along with regular monitoring of liver function tests (see section 4.4 of SmPC).

Paediatric population No paediatric studies have been performed. The safety and efficacy of Clozaril in children and adolescents under the age of 16 years have not yet been established. Clozaril should not be used in this group until further data becomes available.

Patients 60 years of age and older Initiation of treatment is recommended at a particularly low dose (12.5 mg given once on the first day), with subsequent dose increments restricted to 25 mg/day. See SmPC for information on ending therapy.

Contraindications

Hypersensitivity to the active substance or to any of the excipients. Patients unable to undergo regular blood tests. History of toxic or idiosyncratic granulocytopenia / agranulocytosis (with the exception of granulocytopenia / agranulocytosis from previous chemotherapy). History of Clozaril induced agranulocytosis. Concurrent treatment with substances known to have a substantial potential for causing agranulocytosis; concomitant use of depot antipsychotics is discouraged.

Impaired bone marrow function. Uncontrolled epilepsy. Alcoholic and other toxic psychoses, drug intoxication, comatose conditions. Circulatory collapse and/or CNS depression of any cause.

Severe renal or cardiac disorders (e.g. myocarditis). Active liver disease associated with nausea, anorexia or jaundice; progressive liver disease, hepatic failure. Paralytic ileus.

Warnings and Precautions

Agranulocytosis: Before initiating clozapine therapy, patients should have a blood test and a history and physical examination. Clozaril can cause agranulocytosis, so is restricted to patients who have initially normal leukocyte findings (White Blood Cell (WBC) count > 3.5x 10⁹/l and Absolute Neutrophil Count (ANC) > 2.0x 10⁹/l), and in whom regular WBC counts and ANC can be performed within 10 days prior to starting Clozaril, weekly for first 18 weeks, thereafter at 4 week intervals throughout treatment and for 4 weeks after complete discontinuation.

Patients with history of cardiac illness or abnormal cardiac findings on physical examination prior to treatment should be referred to a specialist for other examinations that might include an ECG, and the patient treated only if the expected benefits clearly outweigh the risks. The treating physician should consider performing a pre-treatment ECG.

QT interval prolongation: As with other antipsychotics, caution is advised in patients with known cardiovascular disease or family history of QT prolongation. As with other antipsychotics, caution should be exercised when clozapine is prescribed with medicines known to increase QTc interval.

Cerebrovascular adverse events: Clozapine should be used with caution in patients with risk factors for stroke. Risk of thromboembolism: Cases of venous thromboembolism (VTE) have been reported with antipsychotic drugs. If the diagnosis of NMS is confirmed, Clozaril should be discontinued immediately and appropriate medical measures should be administered. **Metabolic changes:** Atypical antipsychotic drugs, including Clozaril, have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. **Hyperglycaemia:** Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. **Hepatic impairment:** Patients with stable pre-existing liver disorders may receive Clozaril, but need regular liver function tests. Liver function tests should be performed in patients in whom symptoms of possible liver dysfunction, such as nausea, vomiting and/or anorexia, develop during Clozaril therapy.

Prior to treatment initiation, physicians must ensure that the patient has not experienced an adverse haematological reaction to clozapine that necessitated discontinuation.

Immediate discontinuation of Clozaril is mandatory if either the WBC count is less than 3.0x10⁹/l or the ANC is less than 1.5x10⁹/l at any time during Clozaril treatment. Patients in whom Clozaril has been discontinued as a result of either WBC or ANC deficiencies must not be re-exposed to Clozaril. Following discontinuation of Clozaril, haematological evaluation is required until haematological recovery has occurred. **If Clozaril has been withdrawn and either a further drop in the WBC count below 2.0x10⁹/l occurs or the ANC falls below 1.0x10⁹/l the management of this condition must be guided by an experienced haematologist.** The patient should be educated to contact the treating physician immediately if any kind of infection, fever, sore throat or other flu-like symptoms develop. WBC and differential blood counts must be performed immediately if any symptoms or signs of an infection occur.

Low WBC count/ANC: If, during Clozaril therapy, either the WBC count falls to between 3.5x10⁹/l and 3.0x10⁹/l or the ANC falls to between 2.0x10⁹/l and 1.5x10⁹/l, haematological evaluations must be performed at least twice weekly until the patient's WBC count and ANC stabilise within the range 3.0-3.5x10⁹/l and 1.5-2.0x10⁹/l respectively, or higher.

Eosinophilia: Discontinuation of Clozaril is recommended if the eosinophil count rises above $3.0 \times 10^9 / l$; therapy should be restarted only after the eosinophil count has fallen below $1.0 \times 10^9 / l$.
Discontinuation of Thrombocytopenia: Clozaril therapy is recommended if the platelet count falls below $50 \times 10^9 / l$.
Cardiovascular disorders: Orthostatic hypotension, with or without syncope, can occur during Clozaril treatment. Rarely, collapse can be profound and may be accompanied by cardiac and/or respiratory arrest which is more likely to occur with concurrent use of certain medications (See SPC for more details) and during initial titration with rapid dose escalation. Patients starting Clozaril treatment require close medical supervision. Clozaril is associated with an increased risk of myocarditis, pericarditis/pericardial effusion and cardiomyopathy; and if suspected, Clozaril treatment should be promptly stopped and the patient immediately referred to a cardiologist. Patients with clozapine-induced myocarditis or cardiomyopathy should not be re-exposed to Clozaril. In patients who are diagnosed with cardiomyopathy while on Clozaril treatment, there is potential to develop mitral valve incompetence, including mild or moderate mitral regurgitation. Myocarditis or cardiomyopathy should be suspected in patients who experience persistent tachycardia at rest, especially in the first two months of treatment, and/or palpitations, arrhythmias, chest pain and other signs and symptoms of heart failure or symptoms mimicking myocardial infarction. Flu-like symptoms may also be present.
Myocardial infarction (MI): There have been post marketing reports of MI which include fatal cases.
Epilepsy: Patients with a history of epilepsy should be closely observed during Clozaril therapy since dose related convulsions have been reported.
Hepatic impairment: Patients with stable pre-existing liver disorders or liver dysfunction need regular liver function tests. If the LFTs are elevated, discontinue Clozaril and resume only if LFTs return to normal.
Dyslipidemia: Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics, including Clozaril. Clinical monitoring, including baseline and periodic follow-up lipid evaluations in patients using clozapine, is recommended.
Anticholinergic effects: Use with care in patients with a history of colonic disease, a history of lower abdominal surgery, glaucoma, narrow angle glaucoma, prostatic enlargement and in patients receiving concomitant medications known to cause constipation, megacolon and intestinal infarction/ischaemia, paralytic ileus.
Pyrexia: High temperatures should be evaluated carefully to rule out underlying infection, agranulocytosis or Neuroleptic Malignant Syndrome (NMS). If NMS is confirmed, discontinue Clozaril immediately and administer appropriate medical measures. Patients with rare hereditary problems of galactose intolerance should not take Clozaril. Impaired glucose tolerance and/or development or exacerbation of diabetes mellitus has been reported rarely during treatment with clozapine. Falls: Clozaril may cause seizures, somnolence and other conditions that could lead to falls. Fall risk assessments should be performed on patients with exacerbating conditions.
Risk of thromboembolism: Immobilisation of patients should be avoided due to reports of thromboembolism. Increased mortality in elderly patients with dementia.
Caution when prescribing to pregnant women. Mothers receiving Clozaril should not breast-feed. Adequate contraceptive measures must be ensured in women of childbearing potential. Neonates exposed to antipsychotic drugs (including Clozaril), during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress or feeding disorder. Consequently, newborns should be monitored carefully. Activities such as driving or operating machinery should be avoided, especially during the initial weeks of treatment.

Interaction with other medicinal products and other forms of interaction

Clozaril must not be used concomitantly with substances having a well-known potential to suppress bone marrow function. (See Section 4.3 of the SmPC, Contraindications). Long-acting depot antipsychotics (with myelosuppressive potential) must not be used with Clozaril because these cannot be removed from the body in situations where they may be required e.g. neutropenia. Alcohol should not be used with Clozaril due to possible potentiation of sedation.

Caution is advised if Clozaril is used concomitantly with other CNS active agents such as, MAOIs, perazine, SSRIs especially fluvoxamine, caffeine, CNS depressants including narcotics, antihistamines and benzodiazepines, Clozaril is used concomitantly with antihypertensive agents, highly protein bound drugs (e.g. warfarin and digoxin), phenytoin, lithium, rifampicin, valproic acid, noradrenaline [norepinephrine], adrenaline [epinephrine] or omeprazole. Cases have been reported of an interaction between citalopram and clozapine, which may increase the risk of adverse events associated with clozapine. The nature of this interaction has not been fully elucidated. Hormonal contraceptives (including combinations of estrogen and progesterone or progesterone only) are CYP 1A2, CYP 3A4 and CYP 2C19 inhibitors. Therefore initiation or discontinuation of hormonal contraceptives, may require dose adjustment of clozapine according to the individual medical need. In cases of sudden cessation of smoking, the plasma clozapine concentration may be increased, thus leading to an increase in adverse effects. See SPC for more details.

Fertility, Pregnancy and Lactation

Pregnancy: Caution should be exercised when prescribing to pregnant women. Neonates exposed to antipsychotics (including Clozaril) during the third trimester are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, or feeding disorder. Consequently, newborns should be monitored carefully.

Lactation: Animal studies suggest that clozapine is excreted in breast milk and has an effect in the nursing infant; therefore, mothers receiving Clozaril should not breast-feed.

Fertility: Limited data available on the effects of clozapine on human fertility are inconclusive.

Women of child-bearing potential: A return to normal menstruation may occur as a result of switching from other antipsychotics to Clozaril. Adequate contraceptive measures must therefore be ensured in women of childbearing potential.

Ability to Drive and Operate Machinery

Owing to the ability of Clozaril to cause sedation and lower the seizure threshold, activities such as driving or operating machinery should be avoided, especially during the initial weeks of treatment.

Undesirable effects

Adverse reactions are ranked under headings of frequency. Very common ($\geq 1/10$), common ($\geq 1/100$, $< 1/10$), uncommon ($\geq 1/1,000$, $< 1/100$), rare ($\geq 1/10,000$, $< 1/1,000$), very rare ($< 1/10,000$), including isolated reports.

The most serious adverse reactions experienced with clozapine are agranulocytosis, seizure, cardiovascular effects and fever.

Very common: Drowsiness/sedation, dizziness, tachycardia, constipation, hypersalivation.

Common: Leukopenia/decreased WBC/neutropenia, eosinophilia, leukocytosis, weight gain, blurred vision, headache, tremor, rigidity, akathisia, extrapyramidal symptoms, seizures, convulsions, myoclonic jerks, ECG changes, hypertension, postural hypotension, syncope, nausea, vomiting, anorexia, dry mouth, elevated liver enzymes, urinary incontinence, urinary retention, fatigue, fever, benign hyperthermia, disturbances in sweating/temperature regulation, dysarthria.

Uncommon: Agranulocytosis, neuroleptic malignant syndrome, dysphemia, falls.

For details of rare, very rare and not known undesirable effects please refer to SmPC."

Package Quantities and basic NHS price

28 x 25 mg tablets : £2.95 ; 84 x 25 mg tablets : £6.30; 100 x 25 mg tablets : £7.50

28 x 100 mg tablets : £11.76 ; 84 x 100 mg tablets : £25.21 ; 100 x 100 mg tablets : £30.01

Supply of Clozaril is restricted to hospital pharmacies registered with the CLOZARIL Patient Monitoring Service.

Marketing Authorisation Holder

Mylan Products Limited, 20 Station Close, Potters Bar, Herts, EN6 1TL, UK.

Product Authorisation Numbers

25 mg tablets: PL 46302/0054

100 mg tablets: PL 46302/0057

Legal Category: POM

Further information is available in the UK from: BGP Products Ltd., Building Q1, Quantum House, 60 Norden Road, Maidenhead, Berkshire, SL6 4AY, UK.

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Reporting of adverse reactions:

Please continue to report suspected adverse drug reactions with any medicine or vaccine to the MHRA through the Yellow Card Scheme.

It is easiest and quickest to report adverse drug reactions online via the Yellow Card website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Alternatively, you can report via some clinical IT systems (EMIS/SystemOne/Vision/MiDatabank) or by calling the Commission on Human Medicines (CHM) free phone line: 0800-731-6789. Adverse reactions/events should also be reported to Viatriis via cpms@viatriis.com

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