For Prescribers to Complete

LEMTRADA® alemtuzumab 12mg IV

LEMTRADA REMS PATIENT AUTHORIZATION AND BASELINE LAB FORM

Please fax this completed form to the LEMTRADA REMS Program at 1-855-557-2478 or submit online at www.LemtradaREMS.com

This form must be completed within 30 days prior to the first infusion date of each LEMTRADA® (alemtuzumab) patient's treatment course.

*Indicates a mandatory field.

PRESCRIBER INFORMATION (PLEASE PRINT)

Name (Last, First)* | Office Phone Number*

Address*

City* | State* | ZIP Code*

Prescriber LEMTRADA REMS Program Identification Number*

PATIENT INFORMATION (PLEASE PRINT)

Name (Last, First)*

Patient LEMTRADA REMS Program Identification Number*

Date of Birth (MM/DD/YYYY)*

AUTHORIZATION AND BASELINE LABS

Do you authorize LEMTRADA treatment for the above-referenced patient?* ☐ **Yes** ☐ **No**

Do you attest that required baseline laboratory testing has been completed prior to LEMTRADA treatment and within 30 days of the patient's first infusion?* ☐ **Yes** ☐ **No**

PRESCRIPTION INFORMATION

Check one*

☐ Initial course (1 vial [12 mg/day]) X 5 consecutive days — Total number of vials: _____

☐ Subsequent course (1 vial [12 mg/day]) X 3 consecutive days — Total number of vials: _____

SIGNATURE

Prescriber Signature* | Date*

Please fax this completed form to the LEMTRADA REMS Program at 1-855-557-2478 or submit online at www.LemtradaREMS.com

If you have any questions regarding the LEMTRADA REMS Program, call 1-855-676-6326

genzyme A SANOFI COMPANY