Change of LEMTRADA REMS Certified Prescriber: Patient Transfer of Care Form

INSTRUCTIONS:

Please fax this completed form to the LEMTRADA REMS at 1-855-557-2478.

This form is for the purposes of indicating that **<insert patient name>** will continue his/her LEMTRADA (alemtuzumab) therapy under your care. If you have questions about the LEMTRADA REMS requirements, please call the LEMTRADA REMS at 1-855-676-6326.

*INDICATES A MANDATORY FIELD.

PATIENT INFORMATION

Name (Last, First)*

DOB*

Patient REMS ID*

NEW PRESCRIBER INFORMATION (PLEASE PRINT)

Name (Last, First)*

NPI Number*

Prescriber REMS ID#*

Phone*

Fax*

NEW PRESCRIBER SIGNATURE

By completing this form, I certify that I am a LEMTRADA REMS certified prescriber and aware of the REMS prescriber responsibilities. The above-named patient is currently enrolled in the LEMTRADA REMS and will continue in the program.

New Prescriber Signature*

X

Date*

Please visit www.lemtradarems.com for the full Prescribing Information, including Boxed WARNING.

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

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MAT-US-2201239-v2.0-07/2022

LEMTRADA® alemtuzumab 12mg IV