For Healthcare Facilities to Complete

LEMTRADA® alemtuzumab 12mg IV

LEMTRADA REMS INFUSION CHECKLIST

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

As a condition of your healthcare facility's authorization to infuse LEMTRADA® (alemtuzumab), this Infusion Checklist **must** be completed for each patient by the last day of each patient's treatment course and submitted within **5 business days. This Infusion Checklist must also be completed and returned even if LEMTRADA is not infused.** Keep a copy of this checklist in the patient's medical record.

All fields on this form are mandatory.

PATIENT INFORMATION (PLEASE PRINT)

Patient Name (Last, First) | DOB (MM/DD/YYYY)

Patient LEMTRADA REMS Program Identification Number

PRESCRIBER INFORMATION (PLEASE PRINT)

Prescriber Name (Last, First)

Prescriber LEMTRADA REMS Program Identification Number

HEALTHCARE FACILITY INFORMATION (PLEASE PRINT)

Healthcare Facility Name

Healthcare Facility LEMTRADA REMS Program Identification Number

STEP 1: CONFIRM that the patient is authorized to receive LEMTRADA

You must contact the LEMTRADA REMS Program by phone (1-855-676-6326) prior to initiation of each treatment course.

Is the patient authorized to receive LEMTRADA? ☐ **Yes** ☐ **No**

Yes Continue to next question.

No **STOP — DO NOT INFUSE.** Refer patient back to the LEMTRADA prescriber.

STEP 2: CONFIRM that the patient has been counseled and has received *What You Need to Know About LEMTRADA Treatment and Infusion Reactions: A Patient Guide*

The patient must be counseled about the risk for infusion reactions and provided with *What You Need to Know About LEMTRADA Treatment and Infusion Reactions: A Patient Guide* prior to the first infusion of each treatment course. Has the patient been counseled and received the guide?

☐ **Yes** ☐ **No**

Yes Continue to next question.

No **STOP** — provide the patient guide. Proceed to the next question after the patient has received this guide and has been counseled.

STEP 3: CONFIRM appropriate medical measures available for infusion

Appropriate medical support measures are available:

1. In case of serious infusion reactions.
2. To monitor patient's vital signs before, during, and post-infusion.

Are the appropriate medical measures listed above available? ☐ **Yes** ☐ **No**

Yes Continue to next question.

No **STOP — DO NOT INFUSE** until appropriate medical support measures are available. Please contact the LEMTRADA REMS Program for additional information.

PATIENT INFORMATION (PLEASE PRINT)

Patient Name (Last, First)	DOB (MM/DD/YYYY)

STEP 4: RECORD infusion information

Was the patient infused with LEMTRADA? ☐ **Yes** ☐ **No**

Yes Fill in Dates of Infusion below and then proceed to Step 5.

No Proceed to Step 5.

LEMTRADA Infusions

Dates of Infusion:

Date: _____ Date: _____

Date: _____ Date: _____

Date: _____

STEP 5: RETURN unused vials of LEMTRADA

Unused vials of LEMTRADA must be returned within 50 days of submission of the LEMTRADA REMS Patient Authorization and Baseline Lab Form.

Contact the LEMTRADA REMS Program at 1-855-676-6326 for additional information.

Report all adverse events to Genzyme Medical Information at 1-800-745-4447 (option 2) or FDA at 1-800-FDA-1088 (1-800-332-1088) or www.FDA.gov/medwatch

STEP 6: SIGNATURE

_____ _____

Signature of staff completing checklist Date

_____

Name of staff completing checklist (Please Print)

STEP 7: Fax the Infusion Checklist to the LEMTRADA REMS Program at 1-855-557-2478 or submit online at *www.LemtradaREMS.com* within 5 business days

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

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