LEMTRADA REMS Patient Enrollment and Prescription Ordering Form

INSTRUCTIONS FOR PRESCRIBERS:

To enroll a new patient in the LEMTRADA REMS, complete all sections below (A through F). Patient must complete sections D and E.

To submit a prescription order for LEMTRADA for a patient already enrolled in the LEMTRADA REMS, complete sections A (must indicate patient is REMS enrolled and provide the REMS ID), B and C.

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

This form must be completed before you can receive LEMTRADA. Your prescriber will help you complete this form and will give you a copy.

***INDICATES A MANDATORY FIELD. PLEASE PRINT.**

SECTION A: PATIENT INFORMATION

Patient already enrolled in LEMTRADA REMS ☐	LEMTRADA REMS Identification Number (if already enrolled)		
Name (Last, First)*	Date of Birth (MM/DD/YYYY)*		
Street Address*	City*	State*	ZIP Code*
Phone Number*	Gender* ◯ Male ◯ Female ◯ Neutral ◯ Prefer not to say		
Secondary Contact Name (Last, First)	Phone Number		

PRESCRIBER INFORMATION

Prescriber Name (Last, First)*	NPI Number*	Phone Number*

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SECTION B: THIS SECTION SHOULD BE FILLED OUT BY THE PRESCRIBER

INSURANCE INFORMATION† Patient does not have insurance. ☐

Primary Insurance Company	Phone Number	Name of Insured	Policy Number	Group/Policy Number
Secondary Insurance Company	Phone Number	Name of Insured	Policy Number	Group/Policy Number

PRESCRIBER INFORMATION

Prescriber Name (Last, First)*	NPI Number*	Name of Institution or Facility*	Tax
Office Contact*	Street Address*	City*	State* ZIP Code*
Email Address	Phone Number*	Fax Number*	

PRESCRIBER INFORMATION

LEMTRADA 12 mg IV (Check one*)

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

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

Primary diagnosis: ICD-9 CM340
ICD-10 G35

†**Note:** Provision of the patient's insurance coverage(s) is not a requirement of the LEMTRADA REMS, but may support additional services provided by Sanofi Genzyme.

SECTION C: INFUSION CENTER INFORMATION‡

Infusion Center Where Patient Is Referred*	Phone Number*		
Street Address*	City*	State*	ZIP Code*
☐ Ship to a Different Address			
Street Address*	City*	State*	ZIP Code*

‡**Note:** LEMTRADA can only be infused at REMS Certified infusion sites. Sanofi Genzyme will contact you if the infusion center you have indicated is not certified to infuse LEMTRADA.

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SECTION D: PATIENT AGREEMENT

By signing this form, I acknowledge that:

- I have received, read, and understand the LEMTRADA Treatment and Infusion Reactions Patient Guide that my doctor has given to me.
- My doctor has reviewed with me the benefits and risks of treatment with LEMTRADA.
- I am aware that LEMTRADA is associated with serious risks, including autoimmune conditions, infusion reactions, stroke and malignancies, and that these complications can be identified through periodic monitoring and awareness of the initial signs and symptoms.
  - — I understand the need to have blood and urine tests within 30 days prior to my first LEMTRADA treatment, then each month for 4 years following my last treatment with LEMTRADA.
  - — I understand the need to have thyroid testing within 30 days prior to my first LEMTRADA treatment, then every 3 months for 4 years following my last treatment with LEMTRADA.
  - — I understand the need to have yearly skin exams prior to my first LEMTRADA treatment, and continuing for 4 years following my last treatment with LEMTRADA.
  - — I will tell my doctor if I have any reactions or symptoms after receiving LEMTRADA.
- I understand that I must tell all of my doctors that I have received LEMTRADA.
- I understand that in order to receive LEMTRADA, I am required to enroll in the LEMTRADA REMS and my information will be stored in a secure and confidential database of all patients who receive LEMTRADA in the United States. After enrolling, my doctor will provide me with a signed copy of the enrollment form.
- My doctor has counseled and provided me with a LEMTRADA Patient Safety Information Card, which I should carry with me at all times in case of an emergency.
- I understand that I must tell Genzyme if I change my doctor.
- I understand that I must tell Genzyme if my contact information changes.
- I give permission to Genzyme and its agents to use and share my personal health information for the purposes of enrolling me into the LEMTRADA REMS, coordinating the dispensing of receiving LEMTRADA, administering the LEMTRADA REMS, and releasing my personal health information to the Food and Drug Administration (FDA) as necessary.
- By completing the information below, I understand Genzyme and its agents will contact me or my prescriber by phone, mail, or email to support administration of the LEMTRADA REMS.

I prefer to be contacted:

☐ By mail ☐ By phone

☐ By email **(email required to provide digital signature)**

SECTION E: PATIENT SIGNATURE

Patient/Legal Representative Signature*	Relationship to Patient*
Print Name*	Date*

SECTION F: PRESCRIBER SIGNATURE

I acknowledge that I have explained the LEMTRADA REMS to this patient. By signing below, I authorize the LEMTRADA REMS and its agents and representatives to forward this prescription on my behalf to a certified pharmacy or infusion center to dispense LEMTRADA to the patient named above.

Licensed Prescriber Signature* (Signature required; no stamps accepted) **X**	Date*
Print Name*	

Note to Prescribers: This form does not authorize the certified pharmacy or infusion center to dispense LEMTRADA. The LEMTRADA REMS Patient-Authorization and Baseline Lab Form must be submitted in order to authorize LEMTRADA to be dispensed.

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

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

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