LEMTRADA REMS Infusion Checklist

Please fill out this form online by visiting www.LemtradaREMS.com or fax this completed form to the LEMTRADA REMS at 1-855-557-2478

As a condition of your healthcare facility's authorization to infuse LEMTRADA 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 ARE MANDATORY. PLEASE PRINT.

PATIENT INFORMATION

Patient Name (Last, First)	DOB (MM/DD/YYYY)	Patient LEMTRADA REMS Identification Number

PRESCRIBER INFORMATION

Prescriber Name (Last, First)	Prescriber LEMTRADA REMS Identification Number

HEALTHCARE FACILITY INFORMATION

Healthcare Facility Name	Healthcare Facility LEMTRADA REMS Identification Number

STEP 1: CONFIRM THAT THE PATIENT IS AUTHORIZED TO RECEIVE LEMTRADA

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

Is the patient authorized to receive LEMTRADA?

- ◯ **Yes**, continue to STEP 2.
- ◯ **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 *LEMTRADA Treatment and Infusion Reactions Patient Guide* prior to the first infusion of each treatment course.

Has the patient been counseled and received the guide?

- ◯ **Yes**, continue to STEP 3.
- ◯ **No, STOP —** Provide the patient guide. Continue to STEP 3 after the patient has been counseled and received this guide.

STEP 3: CONFIRM APPROPRIATE MEDICAL MEASURES ARE AVAILABLE FOR INFUSION

Appropriate medical support measures must be available in case of serious infusion reactions and to monitor patient's vital signs before, during, and post-infusion.

Are the appropriate medical measures above available?

- ◯ **Yes**, continue to STEP 4.
- ◯ **No, STOP — DO NOT INFUSE** until appropriate medical support measures are available. Please contact the LEMTRADA REMS at 1-855-676-6326 for more information.

LEMTRADA® alemtuzumab 12mg IV

STEP 4: RECORD INFUSION INFORMATION

Was the patient infused with LEMTRADA?

○ **Yes**, fill in dates of infusion below and continue to STEP 5.

○ **No**, continue to STEP 5.

LEMTRADA infusion dates:

Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____

STEP 5: RETURN UNUSED VIALS OF LEMTRADA

Unused vials of LEMTRADA must be returned within 75-business days of submission of the LEMTRADA REMS Patient Authorization and Baseline Lab Form.

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

Report all adverse events to Sanofi 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
Print Name of Staff Completing Checklist	

Please fill out this form online (within 5 business days of a patient's infusion) by visiting 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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