For Prescribers to Complete

LEMTRADA® alemtuzumab 12mg IV

LEMTRADA REMS PATIENT AUTHORIZATION AND BASELINE LAB FORM

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 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 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*

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

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