LEMTRADA® alemtuzumab 12mg IV

LEMTRADA REMS Prescription Ordering Form

Please fax this completed form to 1-855-557-2478

*Indicates a mandatory field.

I: PATIENT INFORMATION (PLEASE PRINT)

Name (Last, First)*

Date of Birth (MM/DD/YYYY)* | Gender* Male ☐ Female ☐

Street Address 1*

Street Address 2*

City* | State* | ZIP Code*

Phone Number*

THIS SECTION SHOULD BE FILLED OUT BY THE PRESCRIBER

II: 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

III: PRESCRIBER INFORMATION

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

IV: PRESCRIPTION INFORMATION

LEMTRADA® (alemtuzumab) 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 Genzyme.

V: INFUSION CENTER INFORMATION†

Infusion center where patient is referred* | Phone Number*

Street Address*

City* | State* | ZIP Code*

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

VI: SIGNATURE

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.

By signing below, I authorize the LEMTRADA REMS Program 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.

X _____

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

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

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

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