



LEMTRADA REMS PHARMACY ENROLLMENT FORM

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

LEMTRADA® (alemtezumab) is only available through the LEMTRADA REMS, a restricted distribution program. Only prescribers, pharmacies, healthcare facilities, and patients enrolled in the program are able to prescribe, dispense, administer, and receive LEMTRADA. An authorized representative of the pharmacy must enroll the pharmacy in the LEMTRADA REMS.

- New Enrollment
 Re-enrollment (every 2 years)

*Indicates a mandatory field.

PHARMACY INFORMATION (PLEASE PRINT)

Name of Pharmacy*		NPI Number*	
Pharmacy Address*			
City*		State*	ZIP Code*
Name of Authorized Pharmacy Representative*		Title*	
Phone Number*	Fax Number*	Email Address	

PHARMACY AGREEMENT

I am the authorized representative designated by my pharmacy to coordinate the activities of the LEMTRADA REMS. By signing this form, I agree to comply with the following program requirements:

- I understand that my pharmacy must be certified with the LEMTRADA REMS to dispense LEMTRADA.
- I will oversee implementation and compliance with the LEMTRADA REMS requirements.
- I have reviewed the LEMTRADA REMS Program Overview.
- I will ensure that all relevant staff involved in the dispensing of LEMTRADA are educated and trained using the LEMTRADA REMS.
- I will put processes and procedures in place, and follow such processes and procedures, to ensure the following verifications are met prior to dispensing LEMTRADA:
 - The LEMTRADA REMS Prescription Ordering Form is received for each prescription.
 - The prescriber is certified, the infusion site is certified, and the patient is enrolled and authorized to receive LEMTRADA by contacting the LEMTRADA REMS prior to dispensing LEMTRADA.
- Ensuring LEMTRADA is only dispensed to a certified infusion center.
- This pharmacy will establish procedures and protocols that are subject to audit, to help ensure compliance with the requirements of the LEMTRADA REMS.
- I understand that my pharmacy must renew enrollment in the LEMTRADA REMS every 2 years from initial enrollment.
- To make available to Genzyme, documentation to verify understanding of, and adherence to, the requirements of the LEMTRADA REMS.

SIGNATURE

Authorized Pharmacy Representative Signature*	Date
Print Name*	Title

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