



LEMTRADA REMS PATIENT AUTHORIZATION AND BASELINE LAB FORM

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

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 Program 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 Program, call 1-855-676-6326