For Patients to Complete

LEMTRADA® alemtuzumab 12mg IV

LEMTRADA REMS PATIENT ENROLLMENT FORM

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

This form must be completed before you can receive LEMTRADA® (alemtuzumab). LEMTRADA is available only through a restricted distribution program called the LEMTRADA REMS Program. Your prescriber will help you complete this form and will give you a copy.

*Indicates a mandatory field.

PATIENT INFORMATION (PLEASE PRINT)

Name (Last, First)*	Date of Birth (MM/DD/YYYY)*		
Street Address*	City*	State*	ZIP Code*
Phone Number*	Gender* ☐ Male ☐ Female		
Secondary Contact (Last, First)	Phone Number		

PRESCRIBER INFORMATION (PLEASE PRINT)

Prescriber Name (Last, First)*	NPI Number*	Phone Number*

PATIENT AGREEMENT

By signing this form, I acknowledge that:

- I have received, read, and understand *What You Need to Know About LEMTRADA Treatment: A Patient Guide* that my doctor has given to me.
- My doctor has reviewed with me the benefits and risks of treatment with LEMTRADA.
- I am aware that LEMTRADA is associated with serious risks, including autoimmune conditions, infusion reactions, and malignancies, and that these complications can be identified through periodic monitoring and awareness of the initial signs and symptoms.
- I understand the need to have blood and urine tests within 30 days prior to my first LEMTRADA treatment, then each month for 4 years following my last treatment with LEMTRADA.
- I understand the need to have thyroid testing within 30 days prior to my first LEMTRADA treatment, then every 3 months for 4 years following my last treatment with LEMTRADA.
- I understand the need to have yearly skin exams prior to my first LEMTRADA treatment, and continuing for 4 years following my last treatment with LEMTRADA.
- I will tell my doctor if I have any reactions or symptoms after receiving LEMTRADA.
- I understand that I must tell all of my doctors that I have received LEMTRADA.
- I understand that in order to receive LEMTRADA, I am required to enroll in the LEMTRADA REMS Program and my information will be stored in a secure and confidential database of all patients who receive LEMTRADA in the United States. After enrolling, my doctor will provide me with a signed copy of the enrollment form.
- My doctor has counseled and provided me with a LEMTRADA Patient Safety Information Card, which I should carry with me at all times in case of an emergency.
- I understand that I must tell Genzyme if I change my doctor.
- I understand that I must tell Genzyme if my contact information changes.
- I give permission to Genzyme and its agents to use and share my personal health information for the purposes of enrolling me into the LEMTRADA REMS Program, coordinating the dispensing of receiving LEMTRADA, administering the LEMTRADA REMS Program, and releasing my personal health information to the Food and Drug Administration (FDA) as necessary.
- By completing the information below, I understand Genzyme and its agents will contact me via phone, mail, or email to support administration of the LEMTRADA REMS Program.

I prefer to be contacted:

☐ By mail ☐ By phone

☐ By email (please provide email address)

_____

PATIENT SIGNATURE

Patient/Legal Representative Signature* _____ Relationship to Patient* _____

Print Name* _____ Date* _____

PRESCRIBER SIGNATURE

I acknowledge that I have explained the LEMTRADA REMS Program to this patient.

Prescriber Signature* _____ Date* _____

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

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