

*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* <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address 1*		
Street Address 2*		
City*	State*	ZIP Code*
Phone Number*		

## THIS SECTION SHOULD BE FILLED OUT BY THE PRESCRIBER

<b>II: INSURANCE INFORMATION</b> Patient does not have insurance. <input checked="" type="checkbox"/>				
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
<b>III: PRESCRIBER INFORMATION</b>				
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*		
<b>IV: PRESCRIPTION INFORMATION</b>				
LEMTRADA® (alemtuzumab) 12 mg IV				
Check one* <input type="checkbox"/> Initial course (1 vial [12 mg/day]) X 5 consecutive days		Total number of vials ordered: _____		Primary diagnosis: ICD-9 CM340
<input type="checkbox"/> Subsequent course (1 vial [12 mg/day]) X 3 consecutive days		Total number of vials ordered: _____		ICD-10 G35

## 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**