

ZINBRYTA REMS Program Patient Enrollment Form

ZINBRYTA is available only through the ZINBRYTA REMS Program, a restricted distribution program. Only prescribers, pharmacies, and patients enrolled in the program are able to prescribe, dispense, and receive ZINBRYTA. Your certified healthcare provider will help you complete this form and provide you with a copy. Fields marked with * are required.



Please submit this completed form to the ZINBRYTA REMS Program via fax or mail:
☎ 1-855-474-3067 ✉ 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709
If you have any questions regarding the ZINBRYTA REMS Program, call: 1-800-456-2255

PATIENT INFORMATION (PLEASE PRINT)

<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
First name*	Last name*	Date of birth*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address*	City*	State*	Zip*
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email	Primary phone*	Secondary phone	
Preferred method(s) of contact*: <input type="checkbox"/> Primary phone <input type="checkbox"/> Email			

In addition, I give permission and allow for the sharing of my health information to the designated individual named below. Biogen may contact the individual designated below to discuss my enrollment in the ZINBRYTA REMS Program.

<input type="text"/>	<input type="text"/>
Designated individual	Relationship
<input type="text"/>	<input type="text"/>
Email	Phone

PRESCRIBER INFORMATION (PLEASE PRINT)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name*	Last name*	Phone*	NPI #*

PATIENT AGREEMENT

By signing this form, I understand and acknowledge that:

- I have received, read, and understand the ZINBRYTA REMS Program Patient Guide that my doctor has given me.
- In order to receive ZINBRYTA, I am required to enroll in the ZINBRYTA REMS Program, and my information will be stored in a secure database of all patients who receive ZINBRYTA in the United States. After enrolling, my doctor will provide me with a signed copy of this enrollment form.
- ZINBRYTA can cause serious side effects. It can cause serious liver problems (including autoimmune-related problems) that may lead to death. ZINBRYTA can also cause other immune system problems. These complications can be identified through monthly testing and awareness of side effects, reactions, or symptoms. My doctor has reviewed with me the risks of treatment with ZINBRYTA.
- I must complete liver testing before my first dose of ZINBRYTA, every month (before my next dose) during ZINBRYTA treatment, and for 6 months after discontinuation of ZINBRYTA. It is important that I complete these monthly blood tests to check my liver, even if I am feeling well.
- I will not be able to receive ZINBRYTA if I do not complete the required monthly liver testing.
- I will tell my doctor if I have any side effects, reactions, or symptoms after receiving ZINBRYTA.
- My doctor has counseled and given me the ZINBRYTA REMS Program Patient Wallet Card, which I will carry with me at all times. I will show this card to all my doctors involved in my medical treatment, even if it is not for my MS.
- I will tell all of my doctors that I have been treated with ZINBRYTA.
- I will tell the ZINBRYTA REMS Program right away if I change my ZINBRYTA doctor, if my contact information changes, or if I discontinue ZINBRYTA.
- I give permission to Biogen and its agents to use and share my personal health information for the purposes of enrolling me into and administering the ZINBRYTA REMS Program, coordinating the dispensing of ZINBRYTA, and releasing my personal health information to the Food and Drug Administration (FDA), as necessary.
- Biogen and its agents may contact me via phone, mail, or email to support administration of the ZINBRYTA REMS Program.

PATIENT ACKNOWLEDGMENT

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient/Patient representative signature	Print name	Relationship to patient	Date

PRESCRIBER ACKNOWLEDGMENT

I have reviewed and discussed the risks of ZINBRYTA and the requirements of the ZINBRYTA REMS Program with this patient, and baseline liver testing will be completed prior to this patient's first dose of ZINBRYTA.

<input type="text"/>	<input type="text"/>
Prescriber signature	Date