

ZINBRYTA REMS Program Prescriber 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.



Instructions:

1. Review the ZINBRYTA Prescribing Information, the ZINBRYTA REMS Program Overview, and the ZINBRYTA REMS Program Prescriber Training
2. Complete the ZINBRYTA REMS Program Prescriber Knowledge Assessment and this ZINBRYTA REMS Program Prescriber Enrollment Form
3. Submit the ZINBRYTA REMS Program Prescriber Knowledge Assessment and the ZINBRYTA REMS Program Prescriber Enrollment Form. Please complete all mandatory fields on this form to avoid a delay in the enrollment process. Upon completion of these steps, the ZINBRYTA REMS Program will contact you to finish certification.

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

PRESCRIBER INFORMATION (PLEASE PRINT)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name*	First Name*	Email
<input type="text"/>		
Address*		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City*	State*	ZIP*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Phone Number*	Fax Number*	Mobile Phone Number
<input type="text"/>		
Clinical/Hospital Affiliation		
<input type="text"/>	Best time(s) to contact: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	Preferred method(s) of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax
National Provider Identification (NPI) Number*		
<input type="text"/>	<input type="text"/>	
State License #	Tax ID #	

*Mandatory Field

OFFICE CONTACT INFORMATION (PLEASE PRINT)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Contact Name	Office Contact Email	Office Contact Phone

PRESCRIBER AGREEMENT

By completing this form, I understand and agree that:

- ZINBRYTA is only available through the ZINBRYTA REMS Program and I must comply with the program requirements in order to prescribe ZINBRYTA.
 - I have reviewed the ZINBRYTA Prescribing Information, ZINBRYTA REMS Program Overview, and ZINBRYTA REMS Program Prescriber Training and must successfully complete the ZINBRYTA REMS Program Knowledge Assessment.
 - By completing the certification requirements and signing this ZINBRYTA REMS Program Prescriber Enrollment Form, I will be enrolled in the ZINBRYTA REMS Program and can prescribe ZINBRYTA.
 - In order to prescribe ZINBRYTA to a patient, I must enroll the patient in the ZINBRYTA REMS Program by:
 - i. Counseling each patient about the risks of severe and fatal hepatic injury and serious immune mediated disorders associated with ZINBRYTA and the need for baseline and monthly liver testing, using the ZINBRYTA REMS Program Patient Guide and ZINBRYTA REMS Program Patient Wallet Card, and providing a copy of each to the patient.
 - ii. Completing and submitting the ZINBRYTA REMS Program Patient Enrollment Form for each patient to the ZINBRYTA REMS Program, storing a copy in the patient's records, and providing a copy to the patient.
 - I understand the risks of severe and fatal hepatic injury and serious immune-mediated disorders associated with the use of ZINBRYTA, and the requirement for baseline and monthly monitoring in order to identify and mitigate these risks.
- I am responsible for ordering and evaluating serum transaminases (ALT and AST) and total bilirubin levels prior to each patients' first dose of ZINBRYTA.
 - I am responsible for ordering and evaluating ALT, AST and total bilirubin every month (prior to the next dose) during treatment and monthly for 6 months after the last dose of ZINBRYTA. A patient who does not complete the required liver testing cannot receive ZINBRYTA.
 - I will report any adverse events suggestive of hepatic injury or immune-mediated disorders to the ZINBRYTA REMS Program.
 - I will complete and submit the ZINBRYTA REMS Program Patient Status Form every 90 days during treatment and every 90 days for 6 months after discontinuation of ZINBRYTA.
 - I will notify the ZINBRYTA REMS Program if an enrolled patient is no longer under my care or if the patient discontinues treatment with ZINBRYTA.
 - If I do not maintain compliance with the requirements of the ZINBRYTA REMS Program, I will no longer be able to prescribe ZINBRYTA.
 - Biogen and its agents may contact me via phone, mail, fax, or email to support administration of the ZINBRYTA REMS Program.

PRESCRIBER SIGNATURE

Prescriber Signature

Date