



LEMTRADA REMS Prescription Ordering Form

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*

Male

Female

Street Address 1*

Street Address 2*

City*

State*

ZIP Code*

Phone Number*

THIS SECTION SHOULD BE FILLED OUT BY THE PRESCRIBER

II: INSURANCE INFORMATION[†]

Patient does not have insurance.

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

III: PRESCRIBER INFORMATION

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*

IV: PRESCRIPTION INFORMATION

LEMTRADA® (alemtuzumab) 12 mg IV

Check one* Initial course (1 vial [12 mg/day]) X 5 consecutive days

Total number of vials ordered: ____

Primary diagnosis: ICD-9 CM340I

Subsequent course (1 vial [12 mg/day]) X 3 consecutive days

Total number of vials ordered: ____

CD-10 G35

[†]Note: Provision of the patient's insurance coverage(s) is not a requirement of the LEMTRADA REMS but may support additional services provided by Genzyme.

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 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 at 1-855-557-2478

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