

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. Fields marked with * are required.



Instructions:

1. **Review** the ZINBRYTA Prescribing Information, the ZINBRYTA REMS Program Overview, and the ZINBRYTA REMS Program Prescriber Training
2. **Complete** and **submit** the ZINBRYTA REMS Program Prescriber Knowledge Assessment and this ZINBRYTA REMS Program Prescriber Enrollment Form
3. **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 notify you to finish certification.

Please submit this completed form to the ZINBRYTA REMS Program via online, using the ZINBRYTA Program Portal, fax, or mail:
www.zinbrytarems.com ☎ 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, please visit www.zinbrytarems.com or call: 1-800-456-2255.

PRESCRIBER INFORMATION (PLEASE PRINT)

<input type="text"/> Last Name*	<input type="text"/> First Name*	<input type="text"/> Email Address
<input type="text"/> Address*		
<input type="text"/> City*	<input type="text"/> State*	<input type="text"/> ZIP*
<input type="text"/> Office Phone Number*	<input type="text"/> Fax Number*	<input type="text"/> Mobile Phone Number
<input type="text"/> Clinical/Hospital Affiliation		
<input type="text"/> Prescriber NPI Number*	<input type="text"/> Practice NPI Number	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
<input type="text"/> State License Number	<input type="text"/> Tax ID Number	

OFFICE CONTACT INFORMATION (PLEASE PRINT)

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

By completing this form and providing my signature below, I hereby confirm that I have read, understand, and agree with the full Prescriber Agreement of this ZINBRYTA REMS Program Prescriber Enrollment Form.

Prescriber Signature

Date