



## LEMTRADA REMS PATIENT AUTHORIZATION AND BASELINE LAB FORM

**Please fax this completed form to the LEMTRADA REMS at 1-855-557-2478  
or submit online at [www.LemtradaREMS.com](http://www.LemtradaREMS.com)**

This form must be completed within 30 days prior to the first infusion date of each LEMTRADA® (alemtuzumab) patient's treatment course.

\*Indicates a mandatory field.

### PRESCRIBER INFORMATION (PLEASE PRINT)

Name (Last, First)*		Office Phone Number*
Address*		
City*	State*	ZIP Code*
Prescriber LEMTRADA REMS Identification Number*		

### PATIENT INFORMATION (PLEASE PRINT)

Name (Last, First)*
Patient LEMTRADA REMS Identification Number*
Date of Birth (MM/DD/YYYY)*

### AUTHORIZATION AND BASELINE LABS

Do you authorize LEMTRADA treatment for the above-referenced patient?\* ☐ Yes ☐ No

Do you attest that required baseline laboratory testing has been completed prior to LEMTRADA treatment and within 30 days of the patient's first infusion?\* ☐ Yes ☐ No

### PRESCRIPTION INFORMATION

Check one\* ☐ Initial course (1 vial [12 mg/day]) X 5 consecutive days Total number of vials: \_\_\_\_\_

☐ Subsequent course (1 vial [12 mg/day]) X 3 consecutive days Total number of vials: \_\_\_\_\_

### SIGNATURE

\_\_\_\_\_  
Prescriber Signature\* Date\*

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