ZINBRYTA REMS Program Patient Status Form

For Prescribers

This form must be completed every 90 days for all patients treated with ZINBRYTA during treatment and every 90 days for 6 months after discontinuation. Please complete this form and return to the ZINBRYTA REMS Program by the date listed on the form. You may also be contacted for additional information in response to answers provided on this form.

Zinbryta® (daclizumab) 150 mg Subcutaneous Injection

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**.

Today's Date

Due Date

PRESCRIBER INFORMATION (PLEASE PRINT)

Prescriber Name

Prescriber Address

City State ZIP

Prescriber Enrollment ID

PATIENT INFORMATION (PLEASE PRINT)

Patient Name

Patient Enrollment ID Patient Date of Birth

Patient Therapy Status

Is the above-named patient still under the care of the prescriber identified above? ☐ Yes ☐ No

If No, please indicate the name of the prescriber now responsible for this patient's care

Prescriber Name Prescriber Phone Number ☐ Unknown

PATIENT STATUS

1. This patient has completed required liver testing during the last 90 days: ☐ Yes ☐ No
2. Has this patient been diagnosed with any of the following that you have *not already* reported to Biogen in the last 90 days?
   a. Hepatic injury ☐ Yes ☐ No
      · *May include elevated liver enzymes and/or total bilirubin:*
        - *ALT or AST >5x ULN* ***OR***
        - *Total bilirubin >2x ULN* ***OR***
        - *ALT or AST ≥3x ULN but <5x ULN and total bilirubin >1.5x ULN but <2x ULN*
      · *Or a suspected or confirmed diagnosis (e.g. autoimmune hepatitis)*
   b. Immune-mediated disorders ☐ Yes ☐ No
      · *May include skin reactions, lymphadenopathy, autoimmune hemolytic anemia, immune-mediated colitis or other suspected or newly diagnosed single or multi-organ immune-mediated disorder or systemic inflammatory reaction*
3. (On-therapy patients only) This patient will continue to receive ZINBRYTA: ☐ Yes ☐ No

   If no, ZINBRYTA REMS will begin the disenrollment process for the patient, the patient ***will not be eligible to receive ZINBRYTA****, and you will be contacted for patient status information every 90 days for 6 months post-therapy discontinuation.*

ZINBRYTA CERTIFIED PRESCRIBER OR DELEGATE SIGNATURE

Signature Date

Print name

Please note: A ZINBRYTA certified prescriber or delegate may complete and submit this form on behalf of the certified prescriber of record. The certified prescriber of record is responsible for compliance with the ZINBRYTA REMS Program requirements, including monitoring, evaluation, and management of each patient under his/her care. If you have questions on this information, please call 1-800-456-2255.