TOUCH® PRESCRIBING PROGRAM
TYSABRI Outreach: Unified Commitment to Health
Phone: 1-800-456-2255

Please submit this form to:
Biogen
www.touchprogram.com
Fax: 1-800-840-1278

Patient Enrollment Form—Multiple Sclerosis

Completion of all pages required.

Patient Information

Patient name: _____ (First) _____ (MI) _____ (Last) Date of birth: ____/____/____ (MM/DD/YYYY)

_____ (Street address) _____ (City) _____ (State) _____ (ZIP)

_____ - _____ - _____ (Mobile telephone) _____ - _____ - _____ (Home telephone) Patient may be contacted at ☐ Mobile ☐ Home _____ (Best time)

E-mail address: _____

In addition, I allow the sharing of my health information to the person or people I name below. Biogen may contact the people named below to discuss my enrollment in the TOUCH Program.

Designated Individual (print name): _____ Relationship: _____

Patient Acknowledgment

Biogen considers patient safety a priority. Read each section below and **initial in the space provided** if you understand the information. **Do not sign this form if there is anything you do not understand about all the information you have received. Ask your doctor about anything you do not understand before you initial and sign this form.**

I understand that TYSABRI is a medicine approved to treat relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

- I have talked to my doctor and understand the benefits and risks of TYSABRI treatment
- TYSABRI increases the risk of PML. I understand that when starting and continuing treatment with TYSABRI, I should talk to my doctor about whether the expected benefit of TYSABRI is enough to outweigh the risk (see important safety information about PML below)

Initials: _____

I understand that TYSABRI increases my chance of getting a rare brain infection that usually leads to death or severe disability.

- This infection is called progressive multifocal leukoencephalopathy (PML). PML usually happens in people with weakened immune systems
- There is no known treatment, prevention, or cure for PML
- My chance for getting PML may be higher if I am also being treated with other medicines that can weaken my immune system, including other MS treatments. Even if I use TYSABRI alone to treat my MS, I can still get PML
- My chance for getting PML increases if I:
  - — Have been exposed to John Cunningham Virus (JCV). JCV is a common virus that is harmless in most people but can cause PML in people who have weakened immune systems, such as people taking TYSABRI. Most people who are exposed to JCV do not know it or have any symptoms. This exposure usually happens in childhood. My doctor may do a blood test to check if I have been exposed to JCV before I start receiving TYSABRI or during my treatment
  - — Have received TYSABRI for a long time, especially longer than 2 years
  - — Have received certain medicines that can weaken my immune system before I start receiving TYSABRI

  My risk of getting PML is greatest if I have all 3 risk factors listed above. There may be other risk factors for getting PML during TYSABRI treatment that we do not know about yet. My doctor should discuss the risks and benefits of TYSABRI treatment with me before I decide to receive TYSABRI
- I should call my doctor right away if I get any new or worsening symptoms that last several days, especially nervous system symptoms, while I am taking TYSABRI, and for at least 6 months after I stop taking TYSABRI. Some of these symptoms include a new or sudden change in my thinking, eyesight, balance, or strength, but I should also report other new or worsening symptoms

Initials: _____

Patient Acknowledgment continued on next page

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Patient Acknowledgment (continued)

To receive TYSABRI, all patients must be enrolled in a restricted program called the TOUCH® Prescribing Program.

- The TOUCH Prescribing Program is run by the company that makes TYSABRI. Under this program, the company is required to collect information about my health at regular time periods. **I cannot receive TYSABRI if I do not agree** to follow the requirements of the TOUCH Prescribing Program
- The company may use my information to meet the requirements of the TOUCH Prescribing Program, including helping me locate an authorized infusion site
- I must notify the TOUCH Prescribing Program if I switch physicians or infusion sites
- I have received, read, and understand the Patient Medication Guide
- I will have with me a list of all medicines and treatments that I have taken during the past month prior to each TYSABRI infusion

Initials: _____

Patient name: _____ (First) ___ (MI) _____ (Last) Date of birth: ___/___/___ (MM/DD/YYYY)

Patient signature (or personal representative): _____ Date: _____

Authority of personal representative *(if applicable)*: _____

Residents of certain US states (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your personal information. To understand or exercise those rights, California residents please visit https://www.biogen.com/privacy-center/california-policy.html. For more information, visit https://www.biogen.com/privacy-center.html.

Patient History

Date of first MS symptoms: ___/___/___ (MM/DD/YYYY)

Please indicate the patient's **MOST RECENT** therapy for MS (if patient was most recently on combination therapy, check all that apply). ☐ None

☐ Aubagio®	☐ AVONEX®	☐ Azathioprine	☐ Bafiertam®	☐ Betaseron®	☐ Briumvi®	☐ Copaxone®
☐ Cyclophosphamide	☐ Dimethyl Fumarate	☐ Extavia®	☐ Gilenya®	☐ Kesimpta®	☐ Lemtrada®	☐ Mavenclad®
☐ Mayzent®	☐ Methotrexate	☐ Mitoxantrone	☐ Mycophenolate	☐ Ocrevus®	☐ PLEGRIDY®	☐ Ponvory™
☐ Rebif®	☐ TECFIDERA®	☐ TYSABRI®	☐ VUMERITY®	☐ Zeposia®	☐ Other	

Please indicate the start and stop dates of most recent therapy: Start date ___/___ (MM/YYYY) Stop date ___/___ (MM/YYYY)

Has the patient ever received TYSABRI before? ☐ Yes ☐ No

Has the patient **EVER** been prescribed an immunosuppressant or an antineoplastic therapy for any condition? ☐ Yes ☐ No

If yes, please check all of the following that apply:

☐ Azathioprine ☐ Cyclophosphamide ☐ Methotrexate ☐ Mitoxantrone ☐ Mycophenolate ☐ Other

Has the patient **EVER** been tested for the presence of anti-JCV antibodies? ☐ Yes ☐ No ☐ Unknown

If yes, has the patient **EVER** tested **POSITIVE** for the presence of anti-JCV antibodies? ☐ Yes ☐ No ☐ Pending

If an anti-JCV antibody index value is available, please record it here: ___ . ___ ___

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Patient Enrollment Form—Multiple Sclerosis

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Patient name: _____ (First) ___ (MI) _____ (Last) Date of birth: ___/___/_____ (MM/DD/YYYY)

Prescriber

Prescriber name: _____ (First) ___ (MI) _____ (Last)

_____
Prescriber NPI

_____
Street address

___ - ___ - ___
Telephone

_____ _____ _____
City State ZIP

___ - ___ - ___
Fax

Prescriber Acknowledgment

- To my knowledge, this patient has no known contraindications to TYSABRI treatment, including PML
- I have instructed this patient to promptly report to me any continuously worsening symptoms that persist over several days, especially nervous system symptoms
- I have, or another healthcare provider under my direction has, educated this patient on the benefits and risks of treatment with TYSABRI, provided the patient with the Patient Medication Guide and Enrollment Form, instructed the patient to read these materials, and encouraged the patient to ask questions when considering TYSABRI

Prescriber signature: _____ Date: _____

Please see the Prescribing Information, including **BOXED WARNING,** for more information

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Phone: 1-800-456-2255

TYSABRI (natalizumab)
TYS-US-4113v2 05/23

TYSABRI Start Form

Instructions for Healthcare Providers

1. **Have your patients read the Instruction for Patients below and sections I, II, III, IV, and V on pages 2-3. Direct patients to sign or attest to sections A, B, C, D, and E on page 4.**
   - Biogen takes your patient's confidentiality very seriously. Give your patients these pages to keep for reference
   - Sections A and B need to be signed for the patient to receive Biogen Support Services
   - Section C is required for patients to receive marketing communications from Biogen
   - Section D provides the HCP with permission to access the patient's JCV test results via TOUCH® On-Line at *www.touchprogram.com*
   - Section E enables Biogen to provide copay assistance and get your patient on therapy faster via QuickStart
2. **Complete the Prescription for TYSABRI section on page 5 of the Start Form in its entirety.**
   - If available, copy both sides of the patient's medical insurance card and pharmacy benefit card (if different)
3. **Digitally sign or fax the Start Form to 1-800-840-1278.**

As a reminder, the patient and prescriber must be enrolled in the TOUCH Prescribing Program prior to the patient starting TYSABRI.

Instructions for Patients

1. **Read Section I and sign section A: Authorization to Share Health Information.** This permits your healthcare provider, your health insurance company, and your pharmacy providers to disclose to Biogen health information relating to your medical condition, treatment, and insurance coverage.
2. **Read Section II and sign section B: Patient Services Authorization.** This enables Biogen to provide services to support your treatment experience.
3. **Read Section III and sign section C: Marketing Authorization.** This authorizes Biogen to send you marketing communications.
4. **Read Section IV and sign section D: Stratify JCV Test Result Consent.** This enables Biogen and Quest Diagnostics to share Stratify JCV Test results with your HCP via TOUCH® On-Line.
5. **Read Section V and check the the applicable box in section E: Government Payer Attestation.** If eligible, this enables Biogen to provide copay assistance and get you started on therapy faster via QuickStart.

What happens next?

- Expect several important phone calls. You'll see 919-993-7000, a 1-800 number, or "BIOGEN" on your caller ID. Please be sure to answer when you see these calls. They are intended to help you in getting started on TYSABRI as smoothly and quickly as possible

If you have questions or want to learn more about TYSABRI, please call 1-800-456-2255 or visit TYSABRI.com.

PATIENT CONSENT INFORMATION

I. Authorization to Share Health Information

I understand that I have certain rights related to the collection, use, and disclosure of my medical and health information. This information is called "protected health information" (PHI) and includes demographic information (such as sex, race, date of birth, etc.), the results of physical examinations, clinical tests, blood tests, X-rays, and other diagnostic medical procedures that may be included in my medical records. Biogen will not use my PHI without my consent.

By signing this Authorization, I authorize my healthcare provider, my health insurance company and my pharmacy providers ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), health information relating to my medical condition, treatment, and insurance coverage for Biogen to (i) provide me with support services (and related information and materials) related to any of Biogen's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services, and (ii) conduct data analysis, market research and other necessary internal business activities, and (iii) provide me with information about Biogen's products, services, and programs for educational or other purposes. I understand that once I sign this Authorization, and my medical and health information is disclosed to Biogen by the Healthcare Entities, the Health Insurance Portability and Accountability Act (HIPAA) will no longer protect my information because Biogen is not covered by HIPAA. However, Biogen agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Biogen in exchange for the health information and/or for any therapy support services provided to me.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with a Biogen product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive Biogen's therapy support services.

I may cancel this Authorization at any time by mailing a letter to: Biogen, ATTN: [Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709] or emailing privacy@biogen.com. Canceling this Authorization will end my consent to further disclosure of my health information to Biogen by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

Please sign in the space in section A on page 4 to authorize your consent.

II. Patient Services Authorization

By signing this authorization, I authorize Biogen, and companies working with Biogen, to provide me with support services related to any of Biogen's products, including but not limited to: online support, financial assistance services, compliance and persistency and other therapy support services, as well as any information or materials related to such services. I understand and agree that personnel including but not limited to nurses, providing such support services on behalf of Biogen are not employed by my healthcare professional. I authorize Biogen, and companies working with Biogen, to contact me to provide such services and information by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), chat, push notifications and other forms of electronic messaging.

I also authorize Biogen, and companies working with Biogen, to use and disclose my medical and health information in connection with providing the services, including but not limited to, disclosing my information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with my healthcare provider, insurance provider, or pharmacy, or disclosing my information where required by applicable laws or regulations. I also authorize the disclosure of my health information to specific individuals that I have designated.

Please sign in the space in section B on page 4 to authorize your consent.

PATIENT CONSENT INFORMATION

III. Marketing Authorization

By signing this authorization, I authorize Biogen, and companies working with Biogen, to contact me by mail, email, fax, telephone call, and text message for marketing purposes or otherwise provide me with information about Biogen's products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand that Biogen may use auto-dialers, prerecorded messages and artificial voice messages to contact me at the telephone number I have provided on this form and that my mobile provider may charge me to receive these messages.

I understand and agree that any information that I provide may be used by Biogen for marketing purposes, including targeted online marketing, as well as to help develop new products, services, and programs. I understand that Biogen will not sell or transfer my personal information to any unrelated third party for marketing purposes without my express permission. I understand that my consent to receive marketing communications is not required as a condition of purchasing or receiving any goods or services from Biogen. I understand that I may revoke this authorization and choose not to receive services or information from Biogen by mailing a letter to the address above or sending an email with the subject "Unsubscribe" to privacy@biogen.com.

Please sign in the space in section C on page 4 to authorize your consent.

Residents of certain US States (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your personal information. To understand or exercise those rights California residents please visit, https://www.biogen.com/privacy-center/california-policy.html. For more information, visit https://www.biogen.com/privacy-center.html.

I understand that I have the right to receive a copy of the terms and conditions of my agreement with Biogen, and that I may request that copy at the time of signing or at a later date by contacting Biogen at: Biogen, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or emailing privacy@biogen.com.

IV. Opt-in to Stratify JCV Test Result Consent to Release Health Information

I authorize my healthcare provider and my laboratory services provider ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), any current, past, and future Stratify JCV results for upload into TOUCH® On-Line.

Please sign in the space in section D on page 4 to authorize your consent.

V. Government Payer Attestation

Patients with federally funded insurance or a commercial insurer that restricts or prohibits participation in Manufacturer Assistance Program(s), are NOT eligible for certain Biogen programs (such as TYSABRI QuickStart or Biogen Copay Assistance). Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®*, and other governmental insurance are NOT eligible for these programs.

By checking the box on the following page that I **do not** have a government payer, I attest that I either (i) currently do not have federally-funded health insurance, or (ii) will not use my federally funded health insurance to cover any portion of the costs of my Biogen medication while I am enrolled in certain Biogen Programs, and (iii) I agree to notify Biogen immediately if I obtain a federally-funded insurance plan during my enrollment in certain Biogen program(s) and/or choose to use it to cover any portion of the costs of my Biogen medication so that I may be removed from the program.

Please check the appropriate box in section E on page 4 to attest whether or not you have a government payer.

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TYSABRI® (natalizumab)
TYS-US-4113v2 05/23

START FORM

PHONE: 1-800-456-2255 FAX: 1-800-840-1278

PATIENT INFORMATION

Gender: ☐ Male ☐ Female ☐ Non-Binary
☐ Transgender (Male) ☐ Transgender (Female)

First name | Last name

Date of birth | Email address

Address

City | State | Zip

Home phone (patient)
☐ Preferred number
☐ OK to leave detailed voicemail and/or text message

Cell phone (patient)
☐ Preferred number
☐ OK to leave detailed voicemail and/or text message

Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

Patient's preferred language

★ Medical Benefit Information

Primary insurance | Policy #

Group # | Insurance company phone

Policyholder first name | Policyholder last name

☐ Check if patient has secondary insurance

★ Pharmacy Benefit Information

Attach copies of both sides of patient's pharmacy benefit card(s).

☐ Check if no coverage ☐ Check if patient has secondary insurance

Patient's preferred specialty pharmacy

PBM name | PBM phone number

RxBin | RxPCN | Rx group # | Rx ID #

Policyholder first name | Policyholder last name

AUTHORIZATIONS & ATTESTATIONS

I. Authorization to Share Health Information

I have read and understand the *Authorization to Share Health Information* and agree to the terms.

A Signature of patient or patient representative | Date

If signed by patient representative, please explain authority to act on behalf of the patient:

II. Patient Services Authorization

I have read and understand the *Patient Services Authorization* and agree to the terms.

B Signature of patient or patient representative | Date

In addition, I authorize the disclosure of my health information to the following designated individual(s) (optional):

Care partner (print name) | Relationship

Care partner email | Phone

III. Marketing Authorization

I have read and understand the *Marketing Authorization* and agree to the terms.

C Signature of patient or patient representative | Date

IV. Opt-in to Stratify JCV Test Result Consent to Release Health Information

I authorize my healthcare provider and my laboratory services provider ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), any current, past, and future Stratify JCV results for upload into TOUCH® On-Line.

D Signature of patient or patient representative | Date

V. Government Payer Attestation

E Please check the applicable box to attest whether or not you have a government payer:

☐ I attest to all of the statements in Section V on the previous page and confirm that I **do not** have a federally-funded health insurance or will not use my federally-funded health insurance to cover any portion of the costs of my Biogen medication while I am enrolled in certain Biogen programs.

OR

☐ I attest that I **do** have a federally-funded health insurance and intend to use it to cover the costs associated with my Biogen medication.

★ = Required information

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TYSABRI® (natalizumab)

TYS-US-4113v2 05/23

THE FOLLOWING INFORMATION SHOULD BE COMPLETED BY HEALTHCARE PROVIDER

Patient Information

First name | Last name

Date of birth | Street

City | State | Zip | Phone

Statement of Medical Necessity

Primary diagnosis: ICD-10: G35

Current or most recent therapy | Dates/Duration

☐ No prior disease-modifying therapies

Other therapy

Prescription for TYSABRI*

Dose: TYSABRI® (natalizumab) 300 mg Dispense: 1 vial Refills: 12 Directions: IV infusion per Prescribing Information every 4 weeks.

I authorize Biogen as my designated agent and on behalf of my patient to (1) forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient and (2) furnish any information on this form to the insurer of the above-named patient, (3) forward the information on this form to the prescriber or infusion site administering TYSABRI, if applicable, (4) forward the above prescription by fax or by another mode of delivery to a pharmacy, if applicable, and (5) coordinate delivery of TYSABRI on behalf of the above-named patient.

Prescriber signature (dispense as written). | **Date**

*Please consult your state's Board of Pharmacy and Medicaid offices to verify prescribing requirements.

QuickStart Program

☐ Yes, I authorize Biogen to provide up to 3 doses of TYSABRI® at no cost until the patient's prescription coverage is secured. QuickStart dose is for the TYSABRI® medication only and does not cover the cost of administration. The patient must be assigned to an authorized TOUCH® infusion site that will accept free doses. Patient signatures are needed for (I) and (II) above to expedite enrollment in the QuickStart Program.

This program is available only for commercially insured patients in the process of getting started on TYSABRI® and is not available for patients currently enrolled in TOUCH. Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®, and other governmental insurance are not eligible for this program.

Prescriber Information

First name | Last name | Address

City | State | Zip | Phone | Fax

NPI # | Tax ID # | Clinical/Hospital affiliation | Office contact name

Infusion Site Information‡

1 Prescriber will administer TYSABRI and request the following services (check only one):

☐ No services required **OR** ☐ Forward this prescription to a specialty pharmacy provider to investigate pharmacy coverage and coordinate delivery to prescriber's office **OR** ☐ Please conduct insurance research and procurement options for TYSABRI **on-site**

☐ Please conduct insurance research and procurement options for TYSABRI **in-home**

OR

2 Prescriber will refer TYSABRI treatment to another site (check only one):

☐ **I require assistance in locating an infusion site:** **OR** ☐ **I am referring the patient to the following infusion site or healthcare provider:**

Name of infusion site

Name of healthcare provider (first, last)

Street address or site authorization number

City | State | Zip

Office contact telephone

Fax

‡Note: TYSABRI can only be infused by authorized infusion sites. Biogen will contact you if the infusion site you have indicated is not authorized to infuse TYSABRI.

As a reminder, the patient and prescriber must be enrolled in the TOUCH Prescribing Program prior to the patient starting TYSABRI.