

**Patient Information**

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (MM/DD/YYYY)

Patient name \_\_\_\_\_  
 F rst M Last

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Z P \_\_\_\_\_

Work telephone    -    -

Home telephone    -    -

Patient may be contacted at  Home  Work Best time \_\_\_\_\_

Female  Male

E-mail address \_\_\_\_\_

**Insurance Information**

Patient SSN    -   -

**Please attach copies of both sides of patient's insurance and pharmacy card(s).**

Check for insurance  Med care  Medicaid \_\_\_\_\_  
 Medicaid Plan Type

Physician's name \_\_\_\_\_  
 F rst M Last

Primary insurance \_\_\_\_\_ insurance company telephone \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

Pharmacy benefit manager \_\_\_\_\_

**Patient Authorization to Use/Disclose 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 and medical procedures that may be included in my medical records. Biogen Idec will not use my PHI without my consent.

This Authorization form applies to PHI created or obtained by my prescriber, my infusion site, my pharmacy, and my health insurance company. I understand that by signing this Authorization, I authorize my prescriber, infusion site, pharmacy, and/or health insurance company to disclose the PHI in my medical records to Biogen Idec Inc. and its representatives or agents, including information related to my medical condition, treatment, and health insurance, as well as all information provided on any prescription. I also authorize Biogen Idec to use this information to provide TYSABRI support services, such as investigating insurance coverage for TYSABRI and coordinating delivery of TYSABRI to the prescriber or infusion site administering TYSABRI (which may include forwarding my health information to a pharmacy).

I agree to allow Biogen Idec to ask me about and provide me with these support services, educational kits, and other information related to TYSABRI and/or my medical condition. I understand that, once my PHI has been disclosed to Biogen Idec, federal privacy laws may no longer protect the information. However, Biogen Idec agrees to protect my PHI by using it only for the purposes authorized in this Authorization or as required by law.

I understand that I may refuse to sign this Authorization, and refusing to do so will affect my eligibility to receive these additional services but will not affect my ability to receive TYSABRI. I understand that signing this Authorization will not change how my healthcare providers, health insurance plan, and pharmacies provide my medical treatment or payment for treatment or insurance benefits.

I understand that I may cancel all or a part of this Authorization at any time by mailing a letter requesting such cancellation to TYSABRI Support Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709. If I cancel this Authorization, Biogen Idec will end further use and disclosure of my PHI as soon as possible. This will not affect health information that has already been used or disclosed in reliance upon this Authorization.

I will receive a copy of this signed Authorization. This Authorization expires ten (10) years from the date this Authorization is signed.

**Patient signature** (or personal representative): \_\_\_\_\_ Date: \_\_\_\_\_

Authority of personal representative (if applicable): \_\_\_\_\_



**Patient History**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 First MI Last (MM/DD/YYYY)

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

AVONEX®  PLEGRIDY™  Betaseron®  Copaxone®  Rebif®  TYSABRI®  Extavia®  Genya™   
 TECFIDERA®  Aubagio®  LEMTRADA™  Azathioprine  Methotrexate  Mitoxantrone  Mycophenolate   
 Cyclophosphamide  Other

Please indicate the start and stop dates of most recent therapy: Start date /\_\_\_\_/\_\_\_\_ Stop date /\_\_\_\_/\_\_\_\_  
 M M Y Y Y Y M M Y Y Y Y

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

**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 Idec as my designated agent and on behalf of my patient to (1) use the information on this form to enroll the above-named patient in the TOUCH Prescribing Program, (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** (stamps not acceptable): \_\_\_\_\_ Date: \_\_\_\_\_

**Prescriber**

Prescriber name: \_\_\_\_\_ Office contact \_\_\_\_\_  
 First MI Last

Street address \_\_\_\_\_ Tax ID # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ DEA # \_\_\_\_\_

Telephone -\_\_\_\_-\_\_\_\_-\_\_\_\_  
 Fax -\_\_\_\_-\_\_\_\_-\_\_\_\_

NPI/UPIN/provider ID # with patient's insurer(s)

**Continued on next page**



**Patient Information**

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Pat ent name \_\_\_\_\_  
(MM/DD/YYYY) F rst M Last

In add t on, I a ow the shar ng of my hea th nformat on to the person or peop e I name be ow. Biogen Idec may contact the peop e named be ow to d scuss my enro ment n the TOUCH Program.

Designated Individual (pr nt name): \_\_\_\_\_ Relationship: \_\_\_\_\_

**Infusion Site Information\***

**1 Prescriber will administer TYSABRI** and request the fo ow ng serv ces (check on y one):

- No serv ces requ red **OR**  Forward th s presc pt on to a spec a ty pharmacy **OR**  Please conduct nsurance research and procurement opt ons for TYSABRI  
prov der to nvest gate pharmacy coverage and coord nate de very to presc ber's off ce

**OR**

**2 Prescriber will refer TYSABRI treatment to another site** (check on y one):

- I requ re ass stance n ocat ng an nfus on s te **OR**  I am referr ng the pat ent to the fo ow ng nfus on s te or hea thcare prov der:

\_\_\_\_\_  
Name of adm n ster ng hea thcare prov der (f rst, ast) \_\_\_\_\_ Off ce contact \_\_\_\_\_

\_\_\_\_\_  
S te name \_\_\_\_\_ Telephone  -  -

\_\_\_\_\_  
Street address or s te Author zat on Number \_\_\_\_\_ Fax  -  -

\_\_\_\_\_  
C ty \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
\*Note: TYSABRI can on y be nfused at author zed nfus on s tes. Biogen Idec w ll contact you f the nfus on s te you have nd cated s not author zed to nfuse TYSABRI.

**Please see accompanying full Prescribing Information, including Boxed Warning, for important safety information.**

