

# TYSABRI

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

## 6-Month Discontinuation Questionnaire—Crohn's Disease

<Date>

<Prescriber Name>

<Prescriber Address>

<MD Number>

Re: <Patient Name>

Patient Enrollment Number: <Patient TOUCH ID>

Patient date of birth: <MM/DD/YYYY>

Dear <Prescriber Name>,

Our records indicate that <Patient Name> received a final dose of TYSABRI on <MM/DD/YYYY>.

- This Discontinuation Questionnaire is necessary to fulfill the tracking requirements of the TOUCH<sup>®</sup> Prescribing Program for Crohn's disease patients treated with TYSABRI. You may also be contacted for additional information in response to answers provided on this form.
- Submit the completed 6-Month Discontinuation Questionnaire to Biogen via TOUCH On-Line ([www.touchprogram.com](http://www.touchprogram.com)) **OR** fax (1-800-840-1278) and place a copy in the patient's record. This form is mandatory for all discontinued patients.

**A** Is the patient still under <Prescriber Name>'s care?

- Yes     No/I don't know

If **No**, please provide contact information for new prescriber, if available.

Name and phone of new prescriber: \_\_\_\_\_

**B** Is the patient alive?

- Yes     No

Since starting TYSABRI therapy has the patient been diagnosed with any of the following that you have **not** reported to Biogen:

**C** PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY (PML)

- Yes     No    or     Under investigation

**D** OPPORTUNISTIC INFECTION\* for which they have been hospitalized

- Yes     No    or     Under investigation

**E** MALIGNANCY

- Yes     No    or     Under investigation

\*OPPORTUNISTIC INFECTION is defined as an infection due to an organism that generally does not cause disease, or causes only mild or self-limited disease in people with normally functioning immune systems, but causes more significant disease in people with impaired immunity. These infections are frequently severe, prolonged, or disseminated. Examples include esophageal candidiasis, systemic fungal infections, pneumocystis carinii pneumonia, mycobacterial infections (including pulmonary and extra-pulmonary tuberculosis), chronic intestinal cryptosporidiosis, and disseminated viral infections (such as disseminated herpes or cytomegalovirus infections).

**TOUCH Certified Prescriber or Delegate Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(If applicable) Print TOUCH Certified Prescriber or Delegate Name:** \_\_\_\_\_

**Please Note:** A TOUCH certified prescriber or delegate may complete and submit this form on behalf of the certified Prescriber of record. The certified TOUCH Prescriber of record is responsible for compliance with the TOUCH Prescribing Program requirements, including monitoring, evaluation, and management of each patient under his/her care. This questionnaire will be used consistent with the Touch Prescriber/Patient Enrollment Form signed by you and your patient with HIPAA and applicable privacy rules. If you have questions, or if you need additional information, please call 1-800-456-2255.

For full **Prescribing Information**, including **Boxed Warning**, please see [www.TYSABRI.com](http://www.TYSABRI.com).