MS TOUCH PRESCRIBING PROGRAM
TYSABRI Outreach: Unified Commitment to Health

TYSABRI 6-Month Discontinuation Questionnaire—MS

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

Prescriber name: _____
First MI Last

Prescriber address: _____ _____ _____ _____
City State ZIP

Patient: _____ _____ _____ Patient Enrollment Number: _____
First name MI Last name

Patient date of birth (MM/DD/YYYY): _____/_____/_____

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

A Is the patient still under <MD name>'s care?

☐ Yes ☐ No/I don't know

If No, please provide name and phone number for new prescriber, if available _____

_____

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 INFECTIONS__ 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).

F Since <last authorization>, has the patient been tested for the presence of anti-JCV antibodies?

☐ Yes ☐ Not performed

If performed, test result:

☐ Positive ☐ Negative ☐ Pending

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 respons ble 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.

Please see full Prescribing Information, including Boxed Warning, at www.TYSABRI.com

Biogen

TYSABRI (natalizumab)

© 2013-2016 Biogen