TOUCH PRESCRIBING PROGRAM
TYSABRI Outreach: Unified Commitment to Health

Biogen
Fax: 1-800-840-1278
Phone: 1-800-456-2255

Change Prescriber Authorization

By Facsimile

PRESCRIBER AUTHORIZATION REQUESTED

Date:	<Current_Date>	Patient Enrollment Number:	<Alt_ID>
New Prescriber:	<Phys_First_Name> <Phys_Last_Name>	Patient Name:	<Pat_First_Name> <Pat_Last_Name>
Address:	<MD_Address>	Patient DOB:	<Pat_DOB>
	<MD_City>, <MD_State> <MD_Zip>	Patient Enrollment Period:	Pat_Auth_Begin> through <Pat_Auth_End>
Phone:	<MD_Phone>	Infusion Site:	
Fax:	<MD_Fax>	Infusion Site Address:	
Prescriber DEA:		Prescriber State License Number:	

Our records indicate that <Pat_First_Name> <Pat_Last_Name> will continue his/her TYSABRI (natalizumab) therapy under your care. If you agree to accept this patient, please sign this form and fax it to Biogen at 1-800-840-1278.

If you do not accept this patient or have questions about the TOUCH® Prescribing Program Requirements, please call the TOUCH Prescribing Program at 1-800-456-2255. We are available Monday through Friday.

I accept <Pat_First_Name> <Pat_Last_Name> under my care for TYSABRI (natalizumab) treatment.

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) use the information on this form to continue the enrollment of the above-named patient in the TOUCH Prescribing Program, (2) forward the prescription by fax or by another mode of delivery to a pharmacy, if applicable, and (3) coordinate delivery of TYSABRI on behalf of the above named patient.

Prescriber Signature **Date**

FAX this signed form to 1-800-840-1278

For full Prescribing Information including Boxed Warning, please see www.TYSABRI.com

Biogen

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TYSABRI (natalizumab)