

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](http://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

\*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).

**E** MALIGNANCY  
 Yes  No or  Under investigation

**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 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.

Please see full Prescribing Information, including Boxed Warning, at [www.TYSABRI.com](http://www.TYSABRI.com)