

# TYSABRI Patient Status Report and Reauthorization Questionnaire—Crohn's Disease

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

<Date>  
<Prescriber Name>  
<Prescriber Address>  
<MD Number>

Re: <Patient Name>  
Patient Enrollment Number: <Patient TOUCH ID>  
Patient date of birth: <DOB>  
Authorization expiration date: <MM/DD/YYYY>

Dear <MD Name>,

Our records indicate that <Patient Name>'s authorization to receive TYSABRI will expire on <MM/DD/YYYY> and he/she will no longer be able to receive TYSABRI. Please submit the completed form 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.

**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

**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

**G** Is the patient currently receiving or has the patient received systemic steroids for the treatment of Crohn's flare in the previous 6 months?  
 Yes  No  
If Yes, please indicate the number of months of use:  
1 2 3 4 5 6

**H** Within the past year, and since starting TYSABRI, has the patient received greater than 6 consecutive months of systemic steroids for the treatment of Crohn's disease?  
 Yes  No

**I** Is the patient currently receiving or has the patient received any **IMMUNOMODULATORY, or IMMUNOSUPPRESSANT THERAPIES**, in the previous 6 months?  
 Yes  No  
If Yes, please indicate the type of therapy and the number of months of use.

	Months of Use in Last 6 Months					
	1	2	3	4	5	6
Remicade®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humira®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azathioprine or Mercaptopurine or Thioguanine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vedolizumab (Entyvio®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cimzia®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other immunomodulatory or immunosuppressant therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

†Not including aminosalicylates.

**J** If the patient is still under <MD name>'s care **DO YOU AUTHORIZE the continuation of TYSABRI treatment** for the next 6 months for the patient?  
 Yes  No  
If you answer No, Biogen will contact the patient and the infusion site to **STOP TYSABRI TREATMENT**. The patient will not be eligible to receive TYSABRI treatment, and you will receive a final questionnaire for this patient in 6 months.

\***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. The questionnaire will be used consistent with the TOUCH Prescriber/Patient Enrollment Forum 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)



All other trademarks are the marks of their respective owners.

