

Patient Information

Date of birth: _____ / _____ / _____
 (MM/DD/YYYY)

Patient name: _____
 First MI Last

Street address _____

City _____ State _____ ZIP _____

Work telephone - -

Home telephone - -

Patient may be contacted at Home Work Best time: _____

Female Male

E-mail address _____

Insurance Information

Patient SSN - -

Please attach copies of both sides of patient's insurance and pharmacy card(s).

Check if no insurance Medicare Medicaid _____
 Medicaid Plan Type _____

Policyholder's name: _____
 First MI Last

Primary insurance _____ Insurance company telephone _____

Policy number _____ Group number _____

Pharmacy benefit manager _____

Patient Authorization to Use/Disclose Health Information

I understand that I have certain rights related to the collection, use, and disclosure of my medical and health information. This information is called "protected health information" (PHI) and includes demographic information (such as sex, race, date of birth, etc.), the results of physical examinations, clinical tests, blood tests, X-rays, and other diagnostic and medical procedures that may be included in my medical records. Biogen will not use my PHI without my consent.

This Authorization form applies to PHI created or obtained by my prescriber, my infusion site, my pharmacy, and my health insurance company. I understand that by signing this Authorization, I authorize my prescriber, infusion site, pharmacy, and/or health insurance company to disclose the PHI in my medical records to Biogen and its representatives or agents, including information related to my medical condition, treatment, and health insurance, as well as all information provided on any prescription. I also authorize Biogen to use this information to provide TYSABRI support services, such as investigating insurance coverage for TYSABRI and coordinating delivery of TYSABRI to the prescriber or infusion site administering TYSABRI (which may include forwarding my health information to a pharmacy).

I agree to allow Biogen to ask me about and provide me with these support services, educational kits, and other information related to TYSABRI and/or my medical condition. I understand that, once my PHI has been disclosed to Biogen, federal privacy laws may no longer protect the information. However, Biogen agrees to protect my PHI by using it only for the purposes authorized in this Authorization or as required by law.

I understand that I may refuse to sign this Authorization, and refusing to do so will affect my eligibility to receive these additional services but will not affect my ability to receive TYSABRI. I understand that signing this Authorization will not change how my healthcare providers, health insurance plan, and pharmacies provide my medical treatment or payment for treatment or insurance benefits.

I understand that I may cancel all or a part of this Authorization at any time by mailing a letter requesting such cancellation to TYSABRI Support Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709. If I cancel this Authorization, Biogen will end further use and disclosure of my PHI as soon as possible. This will not affect health information that has already been used or disclosed in reliance upon this Authorization.

I will receive a copy of this signed Authorization. This Authorization expires ten (10) years from the date this Authorization is signed.

Patient signature (or personal representative): _____ Date: _____
 Authority of personal representative (if applicable): _____

Patient Acknowledgment

Biogen considers patient safety a priority. Read each section below and initial in the space provided if you understand the information.

Do not sign this form if there is anything you do not understand about all the information you have received. Ask your doctor about anything you do not understand before you initial and sign this form.

I understand that TYSABRI is a medicine approved to treat patients with moderate to severe Crohn's disease who have not been helped enough by, or cannot tolerate, usual Crohn's disease medicines and medicines called tumor necrosis factor (TNF) inhibitors.

- I have talked to my doctor and understand the benefits and risks of TYSABRI treatment
- I understand that I should not take certain medicines that weaken the immune system while I am taking TYSABRI

Initials: _____

I understand that TYSABRI increases my chance of getting a rare brain infection that usually leads to death or severe disability.

- This infection is called progressive multifocal leukoencephalopathy (PML). PML usually happens in people with weakened immune systems
- There is no known treatment, prevention, or cure for PML
- My chance for getting PML may be higher if I am also being treated with other medicines that can weaken my immune system, including other Crohn's disease treatments. Even if I use TYSABRI alone to treat my CD, I can still get PML
- My chance for getting PML increases if I:
 - Have received TYSABRI for a long time, especially longer than 2 years
 - Have received certain medicines that can weaken my immune system before I start receiving TYSABRI
 - Have been exposed to John Cunningham Virus (JCV). JCV is a common virus that is harmless in most people but can cause PML in people who have weakened immune systems, such as people taking TYSABRI. Most people who are exposed to JCV do not know it or have any symptoms. This exposure usually happens in childhood. My doctor may do a blood test to check if I have been exposed to JCV before I start receiving TYSABRI or during my treatment.

My risk of getting PML is greatest if I have all 3 risk factors listed above. There may be other risk factors for getting PML during TYSABRI treatment that we do not know about yet. My doctor should discuss the risks and benefits of TYSABRI treatment with me before I decide to receive TYSABRI

- I should call my doctor right away if I get any new or worsening symptoms that last several days, especially nervous system symptoms, while I am taking TYSABRI and for at least 6 months after I stop taking TYSABRI. Some of these symptoms include a new or sudden change in my thinking, eyesight, balance, or strength, but I should also report other new or worsening symptoms

Initials: _____

To receive TYSABRI, all patients must be enrolled in a restricted program called the TOUCH® Prescribing Program.

- The TOUCH Prescribing Program is run by the company that makes TYSABRI. Under this program, the company is required to collect information about my health at regular time periods. **I cannot receive TYSABRI if I do not agree to follow the requirements of the TOUCH Prescribing Program.** I understand that the TOUCH Prescribing Program does not require me to sign the Authorization included on page 1 of this form
- The company may use my information to meet the requirements of the TOUCH Prescribing Program, including helping me locate an authorized infusion site
- I must notify the TOUCH Prescribing Program if I switch physicians or infusion sites
- I have received, read, and understand the Patient Medication Guide
- I will bring to each TYSABRI infusion a list of all medicines and treatments that I have taken during the last month

Initials: _____

Patient name: _____ **Date of birth:** _____ / _____ / _____
First MI Last (MM/DD/YYYY)

Patient signature (or personal representative): _____ **Date:** _____

Authority of personal representative (if applicable): _____

Patient History

Patient name: _____ DOB: ____/____/____
First MI Last (MM/DD/YYYY)

Date of first Crohn's disease symptoms: _____
(MM/YYYY)

Please indicate the patient's Crohn's disease therapy(ies) within the past one year AND whether the therapy is ongoing or stopped. **Ongoing therapies, except corticosteroids, must be stopped before starting TYSABRI.** (If patient was on multiple therapies, check all that apply.)

Medication	Ongoing	OR	Stopped	Medication	Ongoing	OR	Stopped
<input type="checkbox"/> None				Methotrexate	<input type="checkbox"/>		<input type="checkbox"/>
Remicade®	<input type="checkbox"/>		<input type="checkbox"/>	Systemic steroids	<input type="checkbox"/>		<input type="checkbox"/>
Humira®	<input type="checkbox"/>		<input type="checkbox"/>	Entyvio®	<input type="checkbox"/>		<input type="checkbox"/>
Azathioprine or Mercaptopurine or Thioguanine	<input type="checkbox"/>		<input type="checkbox"/>	Other immunomodulatory therapy or immunosuppressant therapy (not including aminosalicylates)	<input type="checkbox"/>		<input type="checkbox"/>
Cimzia®	<input type="checkbox"/>		<input type="checkbox"/>				

Has the patient had a surgery for Crohn's disease within the previous year? Yes No

Has the patient ever received TYSABRI before? Yes No

Has the patient **EVER** been prescribed an immunosuppressant or an antineoplastic therapy for any condition? Yes No

If yes, please check all of the following that apply:

Remicade Humira Azathioprine or Mercaptopurine or Thioguanine Cimzia Methotrexate
 Systemic steroids Vedolizumab (Entyvio®) Other

Has the patient **EVER** been tested for the presence of anti-JCV antibodies? Yes No Unknown

If yes, has the patient **EVER** tested **POSITIVE** for the presence of anti-JCV antibodies? Yes No Pending

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 enroll the above-named patient in the TOUCH Prescribing Program, (2) furnish any information on this form to the insurer of the above-named patient, (3) forward the information on this form to the prescriber or infusion site administering TYSABRI, if applicable, (4) forward the above prescription by fax or by another mode of delivery to a pharmacy, if applicable, and (5) coordinate delivery of TYSABRI on behalf of the above-named patient.

Prescriber signature (stamps not acceptable): _____ Date: _____

Prescriber

Prescriber name: _____
First MI Last

Office contact _____

Street address _____

Tax ID # _____

City _____ State _____ ZIP _____

DEA # _____

Telephone --
 Fax --

NPI/UPIN/provider ID # with patient's insurer(s) _____

Prescriber Acknowledgment

- I have read and understand the full Prescribing Information for TYSABRI
- I understand that TYSABRI is indicated for adult patients with moderately to severely active Crohn’s disease with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional Crohn’s disease therapies and inhibitors of TNF-α
- I understand that patients receiving TYSABRI should not take concomitant immunosuppressants (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or inhibitors of TNF-α
- I understand that this patient has moderately to severely active Crohn’s disease with evidence of inflammation
- I understand that TYSABRI increases the risk of progressive multifocal leukoencephalopathy (PML), an opportunistic viral infection of the brain that usually leads to death or severe disability. When initiating and continuing treatment with TYSABRI, I should consider whether the expected benefit of TYSABRI is sufficient to offset this risk
- I am aware that cases of PML have been reported in patients taking TYSABRI who were recently or concomitantly treated with immunomodulators or immunosuppressants, as well as in patients receiving TYSABRI monotherapy
- I understand that three risk factors identified thus far that increase the risk of PML in TYSABRI-treated patients are:
 - Longer treatment duration, especially beyond 2 years
 - Prior treatment with an immunosuppressant (e.g., mitoxantrone, azathioprine, methotrexate, cyclophosphamide, mycophenolate mofetil)
 - The presence of anti-JCV antibodies
 These factors should be considered in the context of expected benefit when initiating and continuing treatment with TYSABRI
- I understand that MRI findings may be apparent before clinical signs or symptoms. Periodic monitoring for radiographic signs consistent with PML should be considered to allow for an early diagnosis of PML. Lower PML-related mortality and morbidity have been reported following TYSABRI discontinuation in patients with PML who were initially asymptomatic compared to patients with PML who had characteristic clinical signs and symptoms at diagnosis.
- I have discussed other Crohn’s disease treatments with this patient
- To my knowledge, this patient has no known contraindications to TYSABRI treatment, including PML
- I have instructed this patient to promptly report to me any continuously worsening symptoms that persist over several days, especially nervous system symptoms
- I understand that this patient should be seen and evaluated 3 months after the first infusion, 6 months after the first infusion, every 6 months thereafter, and for at least 6 months after TYSABRI has been discontinued
- I understand that TYSABRI should be discontinued if the patient has not experienced a therapeutic benefit by 12 weeks of therapy
- I will determine every 6 months whether this patient should continue on TYSABRI and if so, authorize treatment for another 6 months. I understand that I am required to submit an "Initial Discontinuation Questionnaire" when TYSABRI is discontinued and a "6-Month Discontinuation Questionnaire" following discontinuation of TYSABRI
- I understand that patients receiving steroid therapy at the time of TYSABRI initiation must undergo a steroid-tapering regimen once a therapeutic response is achieved. If the patient with Crohn’s disease cannot be tapered off steroids within 6 months of starting TYSABRI, TYSABRI should be discontinued
- I should report, as soon as possible, cases of PML, hospitalizations due to opportunistic infection, and any death to Biogen
- I understand that data concerning this patient and me will be entered into the mandatory TOUCH Prescribing Program. Biogen requires my cooperation with periodic data collection. Failure to provide the requested information or otherwise comply with the requirements of the TOUCH Prescribing Program may result in discontinuation of TYSABRI treatment for this patient and termination of my authorization to prescribe TYSABRI
- I have received educational materials regarding the benefits and risks of TYSABRI treatment
- I have, or another healthcare provider under my direction has, educated this patient on the benefits and risks of treatment with TYSABRI, provided him or her with the Patient Medication Guide and Enrollment Form, instructed him or her to read these materials, and encouraged him or her to ask questions when considering TYSABRI

Patient name: _____ **Date of birth:** _____ / _____ / _____
First MI Last (MM/DD/YYYY) Date:

Prescriber signature: _____

Completion of all pages is required.

Patient Information

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In addition, I allow the sharing of my health information to the person or people I name below. Biogen may contact the people named below to discuss my enrollment in the TOUCH Program.

Designated Individual (print name): _____ Relationship: _____

Infusion Site Information*

1 Prescriber will administer TYSABRI and request the following services (check only one):

- No services required OR Forward this prescription to a specialty pharmacy provider OR Please conduct insurance research and procurement options for TYSABRI to investigate pharmacy coverage and coordinate delivery to prescriber's office

OR

2 Prescriber will refer TYSABRI treatment to another site (check only one):

- I require assistance in locating an infusion site OR I am referring the patient to the following infusion site or healthcare provider

 Name of infusion site or healthcare provider (first, last)

 Office contact

 Street address or Site Authorization Number

Telephone - -

Fax - -

 City State ZIP

*Note: TYSABRI can only be infused at authorized infusion sites. Biogen will contact you if the infusion site you have indicated is not authorized to infuse TYSABRI.

Please see Prescribing Information, including Boxed Warning, for important safety information.



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