

TYSABRI 12-Week Questionnaire for 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: <MM/DD/YYYY>

Dear <Prescriber Name> ,

Our records indicate that it has been 12 weeks since <Patient Name> received his or her first dose of **TYSABRI**. The Prescribing Information states that if a patient with Crohn's disease has not experienced a therapeutic benefit by 12 weeks of induction of therapy she/he should be discontinued from **TYSABRI** treatment.

This questionnaire is necessary to fulfill the tracking requirements of the TOUCH[®] Prescribing Program for Crohn's disease patients treated with **TYSABRI**. You may also be contacted for additional information in response to answers provided on this form.

Submit the completed evaluation to Biogen via TOUCH On-Line (www.touchprogram.com) OR fax (1-800-840-1278) and place one copy in the patient's record.

Please answer Yes or No to the following questions:

1. Has this patient experienced a therapeutic benefit within 12 weeks after starting **TYSABRI**

Yes No*

***TYSABRI** should be discontinued if the patient has not experienced a therapeutic benefit by 12 weeks of induction therapy with **TYSABRI**.

2. Will the patient continue on **TYSABRI**?

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 discontinuation questionnaire to complete for this patient.

If you have questions, or if you need additional information, please call 1-800-456-2255.

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. 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.

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