

Certified Pharmacy* Enrollment Form

Please submit this form to:

Biogen

www.touchprogram.com

Fax: 1-800-840-1278

The TOUCH® Prescribing Program was developed as part of the Biogen commitment to patient safety. Only authorized certified pharmacies may dispense to authorized infusion sites. A certified pharmacy may become authorized after it has taken part in compulsory training conducted by Biogen and faxed a completed Enrollment Form to Biogen. Upon receipt of this Enrollment Form, Biogen will send an Authorization Confirmation Letter to provide your Pharmacy Authorization Number and confirm your Shipping Address. This letter will also provide you with the Site Authorization Numbers of any of your associated infusion sites that have been authorized to infuse TYSABRI.

*A certified pharmacy is located within a hospital, group practice, or infusion site and is associated with an infusion site. Retail pharmacies and wholesalers are excluded from holding inventory and dispensing TYSABRI.

Certified Pharmacy Shipping Address

Please note that this is the ONLY address to which TYSABRI will be shipped.

Name of Certified Pharmacy _____

Contact name _____

Address 1 _____

NCPDP _____

Address 2 _____

Title/position _____

City _____ State _____ ZIP _____

Telephone - -

Fax - -

Authorized Infusion Site Name

Please list all potential infusion sites that your pharmacy supports. If you need additional space, please attach a separate page.

1 Name of Infusion Site _____

Contact name _____

Address _____

City _____ State _____ ZIP _____

2 Name of Infusion Site _____

Contact name _____

Address _____

City _____ State _____ ZIP _____

3 Name of Infusion Site _____

Contact name _____

Address _____

City _____ State _____ ZIP _____

4 Name of Infusion Site _____

Contact name _____

Address _____

City _____ State _____ ZIP _____

I confirm that the above information is correct. I understand that by signing this form this pharmacy agrees to dispense TYSABRI only to authorized infusion sites that have been authorized according to the TOUCH Prescribing Program.

I understand that I am to contact Biogen if my pharmacy name or shipping address changes. By signing below, I understand that I am the TOUCH Trained Representative at the certified pharmacy and am responsible for what is outlined in the "Certified Pharmacy Acknowledgment" below.

Certified Pharmacy Acknowledgment

- The pharmacy has received training and educational materials on the TOUCH Prescribing Program for use in the following indication(s):
 MS CD (check all that apply)
- Certified pharmacies may dispense TYSABRI only to authorized infusion sites
- I understand that, per the requirements of the TOUCH Prescribing Program, this certified pharmacy's compliance may be reviewed by the Food and Drug Administration (FDA), and/or audited by Biogen, and/or a third party designated by Biogen
- I understand that noncompliance with the requirements of the TOUCH Prescribing Program may result in my pharmacy no longer being enrolled and termination of our participation in the program

Responsible party acknowledgment: _____ Date: _____

Name: _____ Title: _____

Please see the Prescribing Information, including **BOXED WARNING**, for more information

