

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

Dear <MD Name>,
Our records indicate that <Patient Name> received a final dose of TYSABRI on <MM/DD/YYYY>.

TYSABRI Initial Discontinuation Questionnaire–Crohn’s Disease

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

Re: <Patient Name>
Patient Enrollment Number: <Patient TOUCH ID>
Patient date of birth: <DOB>

- This Initial Discontinuation 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 Initial Discontinuation Questionnaire to Biogen via TOUCH On-Line (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

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, since <last authorization>, test result:
 Positive Negative Pending
 If an anti-JCV antibody index value is available, please record it here: _____

G Since <MM/DD/YYYY> is the patient currently receiving or has the patient received systemic steroids for the treatment of a Crohn’s flare?
 Yes No
 If Yes, please circle 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 Since <MM/DD/YYYY> is the patient currently receiving or has the patient received any **IMMUNOMODULATORY** or **IMMUNOSUPPRESSANT THERAPIES**?
 Yes No
 If Yes, please indicate the type of therapy.
 Cimzia®
 Entyvio®
 Humira®
 Remicade®
 Azathioprine or Mercaptopurine or Thioguanine
 Methotrexate
 Other immunomodulatory or immunosuppressant therapy†
 †Not including aminosaliclates.

***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 this form and submit 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 the Prescribing Information, including **BOXED WARNING**, for more information