

TYSABRI Patient Status Report and Reauthorization Questionnaire-MS

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) **OR** fax (1-800-840-1278) on <expiration date> 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, since <last authorization>, test result:
 Positive Negative Pending
 If an anti-JCV antibody index value is available, please record it here: _____

G Is the patient currently receiving or has the patient received intermittent courses of steroids for the treatment of MS relapse in the previous 6 months?
 Yes No
 If Yes, please circle the number of months of use:
 1 2 3 4 5 6 >6

H 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.

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Aubagio® | <input type="checkbox"/> Rebif® |
| <input type="checkbox"/> AVONEX® | <input type="checkbox"/> TECFIDERA® |
| <input type="checkbox"/> Betaseron® | <input type="checkbox"/> Azathioprine |
| <input type="checkbox"/> Copaxone® | <input type="checkbox"/> Chronic systemic steroids |
| <input type="checkbox"/> Extavia® | <input type="checkbox"/> Cyclophosphamide |
| <input type="checkbox"/> Gilenya® | <input type="checkbox"/> Methotrexate |
| <input type="checkbox"/> Lemtrada® | <input type="checkbox"/> Mitoxantrone |
| <input type="checkbox"/> Mavenclad® | <input type="checkbox"/> Mycophenolate |
| <input type="checkbox"/> Mayzent® | <input type="checkbox"/> Other immunomodulatory or immunosuppressant therapy |
| <input type="checkbox"/> Ocrevus® | |
| <input type="checkbox"/> PLEGRIDY® | |

I 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. 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

