ENROLL PATIENTS PRESCRIBED TYSABRI IN THE TOUCH® PRESCRIBING PROGRAM

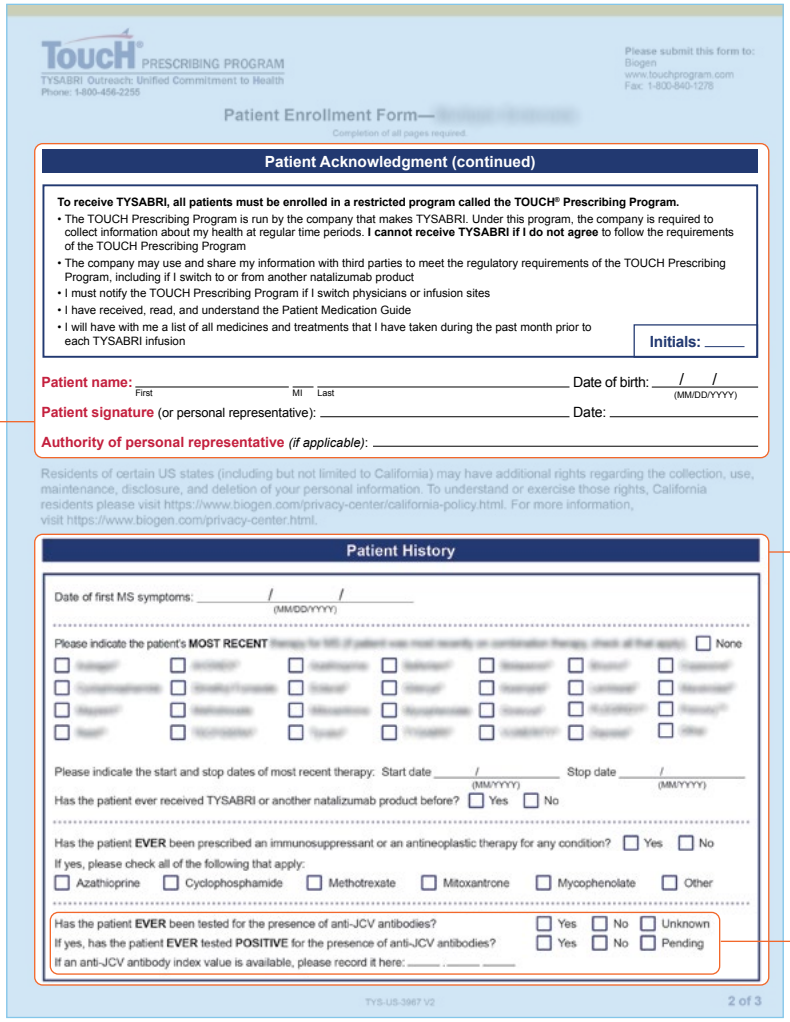
To receive TYSABRI, all patients must be enrolled in the TOUCH® Prescribing Program. Additionally, a separate TOUCH® Start Form is required to begin treatment. For more information on enrolling, contact a Biogen TYSABRI Support Specialist at 1-800-456-2255 (Monday through Friday, 8:30 AM to 8:00 PM ET).

All forms can be completed online at touchprogram.com.

Get your patients started with TYSABRI

When prescribing TYSABRI, you and your patient must complete an enrollment form together. Ask the patient to complete the first page. Confirm they have filled out the acknowledgment and history sections, as noted below.

Patient Acknowledgement
Ensure your patient signs and dates this section to confirm enrollment and acknowledgment of safety information.



TOUCH® PRESCRIBING PROGRAM
TYSABRI Outreach: Unified Commitment to Health
Phone: 1-800-456-2255

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

Patient Enrollment Form—
Completion of all pages required.

Patient Acknowledgment (continued)

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
- The company may use and share my information with third parties to meet the regulatory requirements of the TOUCH Prescribing Program, including if I switch to or from another natalizumab product
- 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 have with me a list of all medicines and treatments that I have taken during the past month prior to each TYSABRI infusion

Initials: ____

Patient name: ____ (First) ____ (MI) ____ (Last) Date of birth: __/__/__ (MM/DD/YYYY)

Patient signature (or personal representative): ____ Date: ____

Authority of personal representative *(if applicable)*: ____

Residents of certain US states (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your personal information. To understand or exercise those rights, California residents please visit https://www.biogen.com/privacy-center/california-policy.html. For more information, visit https://www.biogen.com/privacy-center.html.

Patient History

Date of first MS symptoms: __/__/__ (MM/DD/YYYY)

Please indicate the patient's **MOST RECENT** [illegible] ☐ None

☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]
☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]
☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]
☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]

Please indicate the start and stop dates of most recent therapy: Start date __/__ (MM/YYYY) Stop date __/__ (MM/YYYY)

Has the patient ever received TYSABRI or another natalizumab product 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:

☐ Azathioprine ☐ Cyclophosphamide ☐ Methotrexate ☐ Mitoxantrone ☐ Mycophenolate ☐ 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
If an anti-JCV antibody index value is available, please record it here: ___.___ ___

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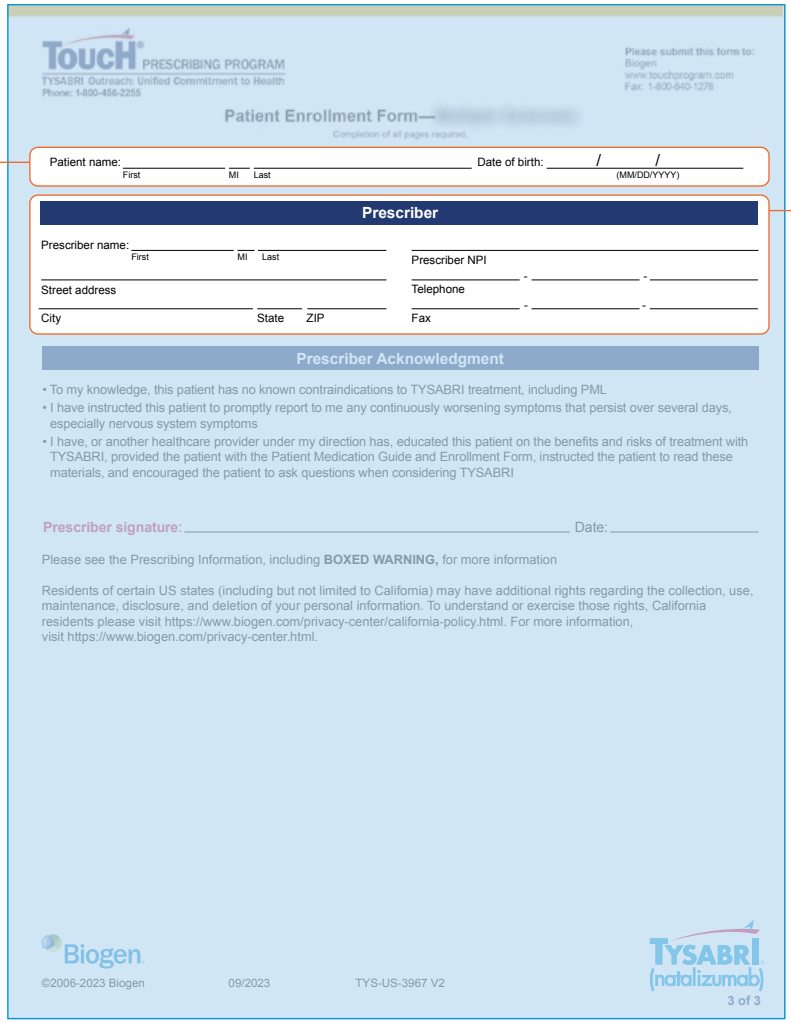
Patient History
Please enter complete patient history, paying special attention to the anti-JCV antibody testing. This information is critical to prescribers for assessing a patient's PML risk.

Please see full Prescribing Information, including **Boxed Warning** and Medication Guide.

ENROLL PATIENTS PRESCRIBED TYSABRI IN THE TOUCH® PRESCRIBING PROGRAM

Once you have confirmed your patient has completed the first page in full, complete the reverse side as the prescriber. Include following information:

Patient Information
Fill in the patient's name to ensure their information is tied to all parts of the form.



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Patient Enrollment Form—[redacted]
Completion of all pages required.

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

Prescriber

Prescriber name: _____ (First) ___ (MI) _____ (Last)
Prescriber NPI _____
Street address _____
Telephone ___-___-____
City _____ State _____ ZIP _____
Fax ___-___-____

Prescriber Acknowledgment

- 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 have, or another healthcare provider under my direction has, educated this patient on the benefits and risks of treatment with TYSABRI, provided the patient with the Patient Medication Guide and Enrollment Form, instructed the patient to read these materials, and encouraged the patient to ask questions when considering TYSABRI

Prescriber signature: _____ Date: _____

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

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TYSABRI (natalizumab)
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Prescriber Information
Enter your name, NPI, and office contact details. Biogen will use this information for verification and any follow-up.

For support, contact TYSABRI Outreach at 1-800-456-2255.

To fill out the TOUCH® Enrollment Form and the TOUCH® Start Form online, please visit touchprogram.com. Print and fax completed forms to 1-800-840-1278.

Please see full Prescribing Information, including **Boxed Warning** and Medication Guide.

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