GETTING YOUR PATIENTS STARTED WITH TYSABRI

This guide outlines the sections of the Start Form that you need to complete to start your patients on TYSABRI. A separate TOUCH® Enrollment Form is necessary to enroll patients in the TOUCH® Prescribing Program.

As a reminder, only prescribers enrolled in the TOUCH® Program may prescribe TYSABRI. For more information on enrolling, contact a TYSABRI Support Specialist at Biogen at 1-800-456-2255 (Monday–Friday, 8:30 AM–8:00 PM ET).

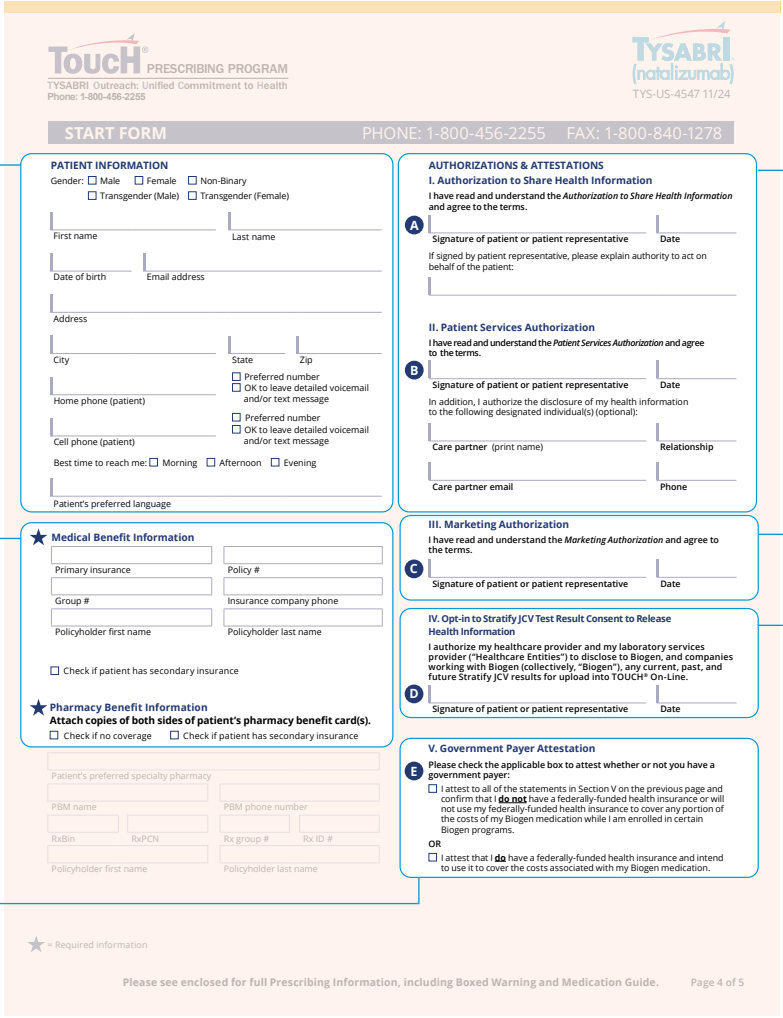
All forms can be completed online at touchprogram.com

Fill out the entire TYSABRI Start Form to get patients started. We've highlighted a few key sections.

Patient Information
Please enter complete patient information including contact information.

Medical and Pharmacy Benefit Information
Enter the patient's medical and pharmacy benefits and attach copies of both sides of the insurance card, if available.

Government Payer Attestation
Providing this information will help Biogen better understand what programs patients may be eligible for.



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

TYSABRI (natalizumab)
TYS-US-4547 11/24

START FORM PHONE: 1-800-456-2255 FAX: 1-800-840-1278

PATIENT INFORMATION
Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender (Male) ☐ Transgender (Female)
First name | Last name
Date of birth | Email address
Address
City | State | Zip
Home phone (patient) ☐ Preferred number ☐ OK to leave detailed voicemail and/or text message
Cell phone (patient) ☐ Preferred number ☐ OK to leave detailed voicemail and/or text message
Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening
Patient's preferred language

★ Medical Benefit Information
Primary insurance | Policy #
Group # | Insurance company phone
Policyholder first name | Policyholder last name
☐ Check if patient has secondary insurance

★ Pharmacy Benefit Information
Attach copies of both sides of patient's pharmacy benefit card(s).
☐ Check if no coverage ☐ Check if patient has secondary insurance
Patient's preferred specialty pharmacy
PBM name | PBM phone number
RxBin | RxPCN | Rx group # | Rx ID #
Policyholder first name | Policyholder last name

AUTHORIZATIONS & ATTESTATIONS
I. Authorization to Share Health Information
I have read and understand the *Authorization to Share Health Information* and agree to the terms.
A Signature of patient or patient representative | Date
If signed by patient representative, please explain authority to act on behalf of the patient:

II. Patient Services Authorization
I have read and understand the *Patient Services Authorization* and agree to the terms.
B Signature of patient or patient representative | Date
In addition, I authorize the disclosure of my health information to the following designated individual(s) (optional):
Care partner (print name) | Relationship
Care partner email | Phone

III. Marketing Authorization
I have read and understand the *Marketing Authorization* and agree to the terms.
C Signature of patient or patient representative | Date

IV. Opt-in to Stratify JCV Test Result Consent to Release Health Information
I authorize my healthcare provider and my laboratory services provider ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), any current, past, and future Stratify JCV results for upload into TOUCH® On-Line.
D Signature of patient or patient representative | Date

V. Government Payer Attestation
E Please check the applicable box to attest whether or not you have a government payer:
☐ I attest to all of the statements in Section V on the previous page and confirm that I **do not** have a federally-funded health insurance or will not use my federally-funded health insurance to cover any portion of the costs of my Biogen medication while I am enrolled in certain Biogen programs.
OR
☐ I attest that I **do** have a federally-funded health insurance and intend to use it to cover the costs associated with my Biogen medication.

★ = Required information

Please see enclosed for full Prescribing Information, including Boxed Warning and Medication Guide. Page 4 of 5

Authorization and Attestations
When a patient completes the Authorization to Share Health Information and the Patient Services Authorization sections, Biogen is able to provide timely assistance in helping patients get started on TYSABRI.

Marketing Authorization
Patients have the option to receive helpful information on TYSABRI during their treatment journey.

Consent to Release Health Information
By signing this release, HCPs can have access to their Stratify JCV test results in TOUCH® On-line.

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

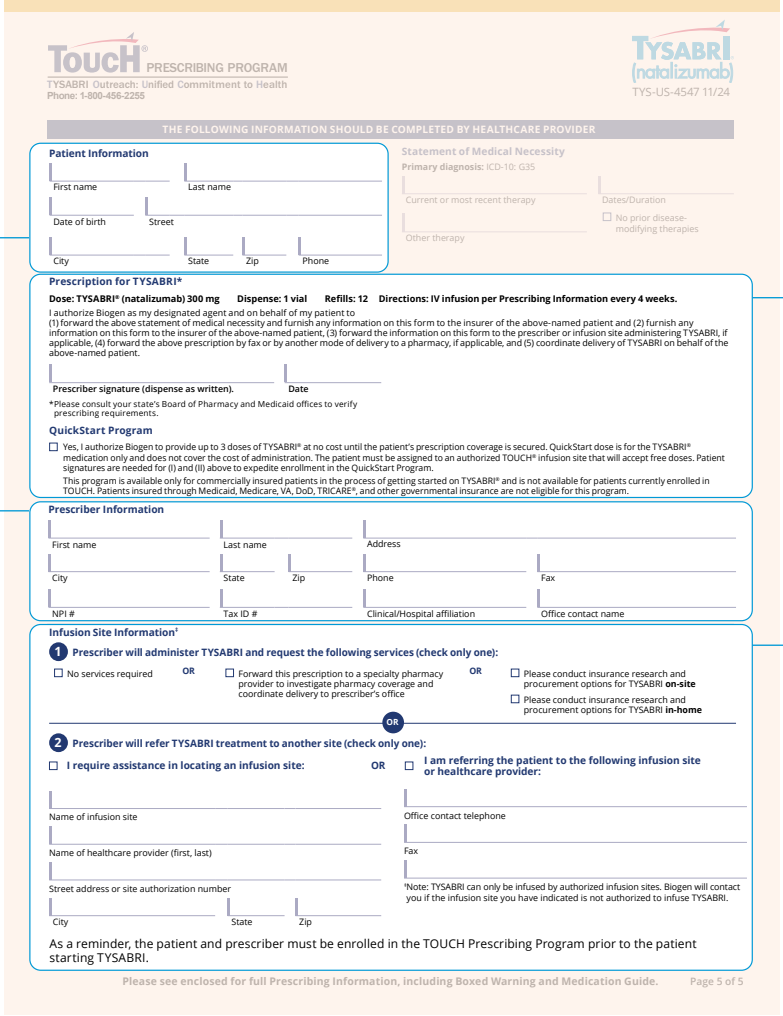
TYSABRI® (natalizumab)

GETTING YOUR PATIENTS STARTED WITH TYSABRI

Fill out the entire TYSABRI Start Form to get patients started. We've highlighted a few key sections.

Patient Information
Fill in the patient's name, date of birth, and contact information.

Prescriber Information
Enter your name, NPI, Tax ID, and office contact details. Biogen will use this information for verification and any follow-up regarding the prescription or infusion site coordination.



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THE FOLLOWING INFORMATION SHOULD BE COMPLETED BY HEALTHCARE PROVIDER

Patient Information
First name | Last name
Date of birth | Street
City | State | Zip | Phone

Statement of Medical Necessity
Primary diagnosis: ICD-10: G35
Current or most recent therapy | Dates/Duration
☐ No prior disease-modifying therapies
Other therapy

Prescription for TYSABRI*
Dose: TYSABRI® (natalizumab) 300 mg Dispense: 1 vial Refills: 12 Directions: IV infusion per Prescribing Information every 4 weeks.
I authorize Biogen as my designated agent and on behalf of my patient to (1) forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient and (2) furnish any information on this form to the insurer of the above-named patient, (3) forward the information on this form to the prescriber or infusion site administering TYSABRI, if applicable, (4) forward the above prescription by fax or by another mode of delivery to a pharmacy, if applicable, and (5) coordinate delivery of TYSABRI on behalf of the above-named patient.
Prescriber signature (dispense as written). | Date
*Please consult your state's Board of Pharmacy and Medicaid offices to verify prescribing requirements.

QuickStart Program
☐ Yes, I authorize Biogen to provide up to 3 doses of TYSABRI® at no cost until the patient's prescription coverage is secured. QuickStart dose is for the TYSABRI® medication only and does not cover the cost of administration. The patient must be assigned to an authorized TOUCH® infusion site that will accept free doses. Patient signatures are needed for (I) and (II) above to expedite enrollment in the QuickStart Program.
This program is available only for commercially insured patients in the process of getting started on TYSABRI® and is not available for patients currently enrolled in TOUCH. Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®, and other governmental insurance are not eligible for this program.

Prescriber Information
First name | Last name | Address
City | State | Zip | Phone | Fax
NPI # | Tax ID # | Clinical/Hospital affiliation | Office contact name

Infusion Site Information†
1 **Prescriber will administer TYSABRI and request the following services (check only one):**
☐ No services required OR ☐ Forward this prescription to a specialty pharmacy provider to investigate pharmacy coverage and coordinate delivery to prescriber's office OR ☐ Please conduct insurance research and procurement options for TYSABRI **on-site** ☐ Please conduct insurance research and procurement options for TYSABRI **in-home**
OR
2 **Prescriber will refer TYSABRI treatment to another site (check only one):**
☐ **I require assistance in locating an infusion site:** OR ☐ **I am referring the patient to the following infusion site or healthcare provider:**
Name of infusion site | Office contact telephone
Name of healthcare provider (first, last) | Fax
Street address or site authorization number
City | State | Zip
†Note: TYSABRI can only be infused by authorized infusion sites. Biogen will contact you if the infusion site you have indicated is not authorized to infuse TYSABRI.

As a reminder, the patient and prescriber must be enrolled in the TOUCH Prescribing Program prior to the patient starting TYSABRI.

Please see enclosed for full Prescribing Information, including Boxed Warning and Medication Guide. Page 5 of 5

Prescription for TYSABRI
Sign, date, and check the box authorizing Biogen to coordinate prescription fulfillment.

Infusion Site Information
Provide an authorized TYSABRI infusion site or request help to find one.

Fax completed forms to 1-800-840-1278.
For support, contact TYSABRI Outreach at 1-800-456-2255.

To fill out the TYSABRI Start Form and the TOUCH® Enrollment Form online, please go to:
https://www.touchprogram.com/

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

Biogen

225 Binney Street, Cambridge, MA 02142 • 1.800.456.2255 • TYSABRI.com