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

TYSABRI Patient Status Report and Reauthorization Questionnaire—Crohn's Disease

Please submit this form to:
Biogen Idec
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 Idec via TOUCH On-Line (www.touchprogram.com) **OR** fax (1-800-840-1278) 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

Has the patient been diagnosed with any of the following that you have *not* reported to Biogen Idec:

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 In the previous **12** months, has the patient been tested for the presence of anti-JCV antibodies? ☐ Yes ☐ No
Date of most recent test: MM/YYYY _____ /_____
If yes, has the patient tested **POSITIVE** for the presence of anti-JCV antibodies in the previous **12** months?
☐ Yes ☐ No

G Is the patient currently receiving or has the patient received systemic steroids for the treatment of Crohn's flare in the previous 6 months?
☐ Yes ☐ No
If Yes, please indicate 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 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 and the number of months of use.

	Months of Use in Last 6 Months					
Remicade®	1	2	3	4	5	6
Humira®	1	2	3	4	5	6
Azathioprine or Mercaptopurine or Thioguanine	1	2	3	4	5	6
Methotrexate	1	2	3	4	5	6
Cimzia®	1	2	3	4	5	6
Other immunomodulatory or immunosuppressant therapy†	1	2	3	4	5	6

†Not including aminosalicylates.

J 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 Idec 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).

Prescriber signature: _____ Date (MM/DD/YYYY): _____ /_____ /_____

(If applicable) Print TOUCH Authorized Prescriber Delegate Name: _____

Please Note: A TOUCH authorized physician may complete this form on behalf of the Prescriber of record. This questionnaire will be used consistent with the TOUCH Prescriber/Patient Enrollment Form signed by you and your patient and with HIPAA and applicable privacy rules.
If you have questions, or if you need additional information, please call 1-800-456-2255 from 8:30 AM to 8:00 PM (ET).

Please see full Prescribing Information, including Boxed Warning, at www.TYSABRI.com

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

TYSABRI Patient Status Report and Reauthorization Questionnaire—MS

Please submit this form to:
Biogen Idec
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 Idec via TOUCH On-Line (www.touchprogram.com) **OR** fax (1-800-840-1278) by <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

Has the patient been diagnosed with any of the following that you have *not* reported to Biogen Idec:

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 In the previous **12** months, has the patient been tested for the presence of anti-JCV antibodies? ☐ Yes ☐ No
Date of most recent test: MM/YYYY _____ /_____

If yes, has the patient tested **POSITIVE** for the presence of anti-JCV antibodies in the previous **12** months?
☐ Yes ☐ No

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 courses received.
1 2 3 4 5 6 >6

H Is the patient currently receiving or has the patient received any **IMMUNOMODULATORY** or **IMMUNOSUPPRESSANT** products in the previous 6 months?
☐ Yes ☐ No

If Yes, please indicate the type of therapy and number of months of use.

	Months of Use in Last 6 Months					
AVONEX®	1	2	3	4	5	6
Betaseron®	1	2	3	4	5	6
Copaxone®	1	2	3	4	5	6
Rebif®	1	2	3	4	5	6
Novatrone®	1	2	3	4	5	6
Extavia®	1	2	3	4	5	6
Gilenya™	1	2	3	4	5	6
Azathioprine	1	2	3	4	5	6
Methotrexate	1	2	3	4	5	6
Mycophenolate	1	2	3	4	5	6
Cyclophosphamide	1	2	3	4	5	6
Chronic systemic steroids	1	2	3	4	5	6
Other immunomodulatory or immunosuppressant theraphy	1	2	3	4	5	6

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 Idec 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.

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Prescriber signature: _____ Date (MM/DD/YYYY): _____ /_____ /_____

(If applicable) Print TOUCH Authorized Prescriber Delegate Name : _____

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TYSABRI (natalizumab)