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

TYSABRI Patient Discontinuation Questionnaire—MS

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

Prescriber name: _____ (First) ___ (MI) _____ (Last)

Prescriber address: _____ (City) _____ (State) _____ (ZIP)

Patient: _____ (First name) ___ (MI) _____ (Last name) Patient Enrollment Number: _____

Patient date of birth (MM/DD/YYYY): _____/_____/_____

- This TYSABRI Patient Discontinuation Questionnaire is necessary to fulfill the tracking requirements of the TOUCH Prescribing Program for all patients treated with TYSABRI. You may also be contacted for additional information in response to answers provided on this form
- Submit the completed TYSABRI Patient Discontinuation Questionnaire to Biogen Idec 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

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

***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).

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

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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TYSABRI (natalizumab)

12/09

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