

By Facsimile

## Notice of Patient Authorization

<INDICATION>

<DATE>

This TOUCH Prescribing Program authorization is valid from  
<Pat\_Auth Begin> through <Pat\_Auth End>.

***This notice is regarding only the patient's enrollment period in the TOUCH Prescribing Program and does not refer to the patient's insurance status or coverage.***

|  |                     |              |
|--|---------------------|--------------|
| <b>Patient:</b> <Pat_First_Name> <Pat_Last_Name> | <b>Indication:</b>  | <Indication> |
| <b>Patient Enrollment Number:</b> <Alt_ID>       | <b>Patient DOB:</b> | <Pat_DOB>    |

|   |                                |
|---|--------------------------------|
| <b>Account:</b> <Acct_Name>                       |                                |
| <b>Site Authorization Number:</b> <Acct_TOUCH ID> |                                |
| <Acct_Address>                                    |                                |
| <Acct_City>, <Acct_State> <Acct_Zip>              |                                |
| <b>Account Phone:</b> <Acct_Phone>                | <b>Account Fax:</b> <Acct_Fax> |

|  |                                   |
|--|-----------------------------------|
| <b>Prescriber:</b> <Phys_First_Name> <Phys_Last_Name> (<Alt_ID>) |                                   |
| <b>Prescriber Phone:</b> <Phys_Phone>                            | <b>Prescriber Fax:</b> <Phys_Fax> |

Our records indicate that <Pat\_First\_Name> <Pat\_Last\_Name> will receive TYSABRI<sup>®</sup> (natalizumab) infusions for <INDICATION> at <Acct\_Name> and is authorized through <Pat\_Auth End>.

Every six (6) months, a patient must be reauthorized in the TOUCH<sup>®</sup> Prescribing Program in order to continue enrollment and remain authorized to receive TYSABRI for <INDICATION>.

If you are unable to verify current authorization status through TOUCH On-Line<sup>®</sup> ([www.touchprogram.com](http://www.touchprogram.com)), have received a Notice of Patient Discontinuation, or have not received an updated Notice of Patient Authorization, do not infuse, and contact Biogen Patient Services.

Per the requirements of the TOUCH Prescribing Program, authorized infusion sites must:

- Verify that the patient is currently authorized to receive TYSABRI prior to each infusion
- Provide the patient with a copy of the Patient Medication Guide prior to each infusion
- Administer and Submit the Pre-infusion Patient Checklist, whether the patient is infused or not, to Biogen ([www.touchprogram.com](http://www.touchprogram.com) or fax to 1-800-840-1278) within one (1) business day of a patient visit.

If you become aware that a patient is discontinuing or switching administration sites, please let us know. Similarly, if Biogen learns of changes in patient treatment, we will bring it to your attention. If you have additional questions, please call Biogen Patient Services at 1-800-456-2255. We are available Monday through Friday, 8:30 AM to 8:00 PM (ET).

**For Full Prescribing Information, including Boxed Warning, please see [www.TYSABRI.com](http://www.TYSABRI.com).**

**Please retain a copy of this notice in the patient's medical record.**

Sincerely,  
TOUCH Prescribing Program

*This fax is intended only for the use of the addressee named herein and contains confidential personal health information. If you are not the intended recipient of this fax, you are hereby notified that any dissemination, distribution or copying of this fax is strictly prohibited. If you have received this fax in error, please immediately call the number above to arrange for its return. You may choose not to receive advertising faxes from Biogen. To opt out of receiving advertising faxes from Biogen (which would not include, for example, faxes related to the provision of services for your patients or faxes otherwise required by law), please call 1-800-456-2255 and provide your name and the fax numbers to which the opt out request relates. We will honor your opt out request within 30 days.*