START FORM

Phone: 1-800-456-2255 Fax: 1-855-474-3067

Indicates required information

AVONEX (interferon beta-1a) START FORM

AVX-US-0371 v8 07/24

A I. Authorization to Share Health Information

I have read and understand the Authorization to Share Health Information and agree to the terms.

Signature of patient or patient representative | Date

If signed by patient representative, please explain authority to act on behalf of the patient.

B II. Patient Services Authorization

I have read and understand the Patient Services Authorization and agree to the terms.

Signature of patient or patient representative | Date

In addition, I authorize the disclosure of my health information to the following designated individual(s) (optional):

Designated individual (print name) | Relationship

Designated individual email | Phone

C III. Marketing Authorization

I have read and understand the Marketing Authorization and agree to the terms.

Signature of patient or patient representative | Date

D IV. Government Payer Attestation

Please check the applicable box to attest whether or not you have a government payer:

☐ 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.

OR

☐ I attest to all of the statements in Section IV 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.

Patient Information

☐ Male ☐ Female

Date of birth | Patient's preferred language

First name | Last name

Address

City | State | Zip

Email

Home phone | Cell phone | ☐ OK to leave message

Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY YOUR HEALTHCARE PROVIDER

Prescription Information

☐ **First Month of AVONEX® with Titration:** Dispense. 1 AVONEX Prefilled Syringe Administration Pack (4 doses) and AVOSTARTGRIP® Titration Kit with no refills. Dispense AVOSTARTGRIP Titration Kit with no refills by Walgreens Specialty Pharmacy®.

Week 1: 1/4 dose Week 2: 1/2 dose

Week 3: 3/4 dose Week 4: Full dose

Needle Size: 1-1/4" 23 Gauge Needle (**included in package**)

Alternate Needle Size: ☐ 1" 25 Gauge Needle (**pharmacy to provide**)

Ongoing Prescription for AVONEX. Based on Plan, Dispense:

☐ 1 AVONEX Administration Pack (4 doses)

☐ 3 AVONEX Administration Packs (12 doses), based on plan.

Refills: 12 (may supply up to 3 months at a time).

Select One Formulation:

☐ **AVONEX PEN®** | 5/8" 25 Gauge Needle | Alternate size not available

☐ **AVONEX Prefilled Syringe** | 1-1/4" 23 Gauge Needle (**included in package**)

☐ 1" 25 Gauge Needle (**pharmacy to provide**)

Pre-/Post-treatment Instructions:

Training Notification

[X] I have discussed AVONEX with my patient and I believe that supplemental injection training by a Nurse Educator is appropriate.

Statement of Medical Necessity

Primary diagnosis: ICD 10: G35 ☐ No prior disease-modifying therapies

Prior therapy: Current or most recent therapy

Dates on therapy | Allergies

Prescriber Information

Best time to contact: ☐ Morning ☐ Afternoon

First name | Last name

Address

City | State | Zip

Phone | Fax

NPI # | State license # | Tax ID #

Clinical/Hospital affiliation | Office contact name | Office contact phone

Medical Benefit Information

Primary insurance | Policy # | Group #

Insurance company phone | Policyholder first name, last name

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

Prescriber Authorization*

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) forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the above-named patient. I certify that the rationale for prescribing AVONEX therapy is for a primary diagnosis of ICD 10: G35, and I will be supervising the patient's treatment accordingly.

Prescriber signature (dispense as written). Signature stamps not acceptable.

Prescriber signature (substitution permitted). Signature stamps not acceptable.

Date

Date

*Please consult your state's Board of Pharmacy and Medicaid offices to verify prescribing requirements. In New York, please attach copies of all prescriptions on Official New York State Prescription forms.The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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