Patient Consent Information (cont'd)

Please read the following. If you agree, respond accordingly on page 4.

III. Marketing Authorization

By signing this Authorization, I authorize Biogen, and companies working with Biogen, to contact me by mobile or online digital media, mail, email, fax, telephone call, and text message (including autodialed and prerecorded calls and messages) for marketing purposes or otherwise provide me with information about Biogen's products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Biogen for marketing, including targeted online marketing, as well as to develop new products, services, and programs. I understand that Biogen will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Biogen. I understand that I may revoke this authorization and choose not to receive information from Biogen by using the link provided in emails I receive from Biogen, sending an email with the subject "Unsubscribe" to **privacy@biogen.com**, or mailing a letter to Biogen, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709. For more information visit **biogen.com/privacy**.

Please sign in the space in Section C on page 4 to authorize your consent.

Residents of certain US States (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your personal information. To understand or exercise those rights California residents please visit **https://www.biogen.com/privacy-center/california-policy.html**. For more information, visit **https://www.biogen.com/privacy-center.html**.

I understand that I have the right to receive a copy of the terms and conditions of my agreement with Biogen, and that I may request that copy at the time of signing or at a later date by contacting Biogen at: Biogen, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or emailing **privacy@biogen.com**.

IV. Government Payer Attestation

Patients with federally funded insurance or a commercial insurer that restricts or prohibits participation in Manufacturer Assistance Program(s), are NOT eligible for certain Biogen programs. Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®*, and other governmental insurance are NOT eligible for these programs.

I attest that I either (i) currently do not have federally-funded health insurance, or (ii) will not use my federally funded health insurance to cover any portion of the costs of my Biogen medication while I am enrolled in the certain Biogen program(s), and (iii) I agree to notify Biogen immediately if I obtain a federally-funded insurance plan during my enrollment in certain Biogen programs and/or choose to use it to cover any portion of the costs of my Biogen medication so that I may be removed from the program.

*TRICARE® is a registered trademark of the Department of Defense, DHA. All rights reserved.

Please check the applicable box in Section D on page 4 to attest whether or not you have a government payer.

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.