Instructions for **patients**

How do I get started?

1. **Read the Patient Consent Information and sign as indicated in the shaded area of the Start Form.** This will enable you to enroll in the Above MS™ program from Biogen, which provides support services such as the $0 Copay Program. (See Avonex.com for eligibility guidelines.)
2. **Be sure to include your email address in the space provided.** By giving us your email address, you can stay up-to-date on the latest news about AVONEX.
3. **Your doctor fills out the rest of the Start Form.** You're done. Your doctor will fax us the Start Form.

What happens next?

- You can expect to receive several important phone calls. These calls will come from a Support Coordinator as well as from your AVONEX pharmacy.
  - You'll see either 919-993-7000, a 1-800 number, or "unknown" on your caller ID. **Please be sure to answer when you see these calls.** They are intended to aid you in getting started on AVONEX as smoothly and quickly as possible.
- Your prescription can be shipped directly to your home.

Help is here if you need it

You are not alone. Above MS™ will provide you with support services throughout your treatment journey.

Comprehensive insurance counseling and financial assistance programs, including the $0 Copay Program*

Nurse Educators are there to provide additional support to you and your care partner through additional injection training with a nurse visit to your home and to respond to questions related to MS and treatment. They are available by phone 24 hours a day, 7 days a week.

Above MS SUPPORT COORDINATORS ARE HERE TO HELP. CALL 1-800-456-2255, MONDAY THROUGH FRIDAY, FROM 8:30 AM TO 8:00 PM (ET).

* Depending on your income or, in some cases, if your medication is obtained from an out-of-network provider, there may be an annual cap that limits the amount of assistance that you can receive over one year. Federal and state laws and other factors may prevent or otherwise restrict eligibility. People covered by Medicare, Medicaid, the VA/DoD, or any other federal plans are not eligible to enroll. Please note that the $0 Copay Program provides a monthly supply of relapsing MS medication. You are eligible to enroll in the $0 Copay Program for as long as you are treated with a Biogen relapsing MS medication.

Indication

AVONEX® (interferon beta-1a) is indicated for the treatment of patients with relapsing forms of multiple sclerosis to slow the accumulation of physical disability and decrease the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

Important Safety Information

- Patients and their caregivers should be advised to report immediately any symptoms of depression, suicidal ideation, or psychosis to their prescribing physician. These symptoms, and cases of suicide, have been reported with increased frequency with patients receiving AVONEX. If a patient develops depression or other severe psychiatric symptoms, cessation of AVONEX therapy should be considered.
- Severe hepatic injury, including cases of hepatic failure, has been reported rarely in patients taking AVONEX. Patients should be monitored for signs of hepatic injury and caution exercised when AVONEX is used concomitantly with alcohol or other drugs associated with hepatic injury.
- Rare cases of anaphylaxis have been reported. Other allergic reactions have included dyspnea, orolingual edema, skin rash and urticaria.
- While beta interferons do not have any known direct cardiac toxicity, cases of congestive heart failure, cardiomyopathy, and cardiomyopathy with congestive heart failure have been reported in patients without known predisposition. Patients with these pre-existing conditions should be monitored for worsening of their cardiac condition during initiation and continued treatment with AVONEX.
- Decreased peripheral blood counts in all cell lines, including rare pancytopenia and thrombocytopenia, have been reported from postmarketing experience.
- Seizures have been reported in patients using AVONEX, including in patients with no prior history of seizure. It is not known whether these events were related to the effects of multiple sclerosis alone, to AVONEX, or to a combination of both.
- Autoimmune disorders of multiple target organs have been reported. If patients develop a new autoimmune disorder, consider stopping therapy.
- Routine periodic blood chemistry, hematology, liver function, and thyroid function tests are recommended during treatment with AVONEX.
- There are no adequate and well-controlled studies in pregnant women. AVONEX should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- The most common side effects associated with AVONEX treatment are flu-like symptoms including chills, fever, myalgia, and asthenia.

Please see full Prescribing Information for additional important safety information.

AVX-US-0038

Patient consent information

Please read the following. If you agree, sign and date the corresponding section on the following page.

I. Authorization to Share Health Information

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), health information relating to my medical condition, treatment, and insurance coverage for Biogen to provide me with (i) support services (and related information and materials) related to any of Biogen's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services, (ii) conduct data analytics, market research and other internal business activities, and (iii) information about Biogen's products, services, and programs and other topics of interest for marketing, educational or other purposes. Once my health information has been disclosed to Biogen , I understand that federal privacy laws no longer protect the information. However, Biogen agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Biogen in exchange for the health information and/or for any therapy support services provided to me.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with a Biogen product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive Biogen's therapy support services .

I may cancel this Authorization at any time by mailing a letter to: Biogen, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or visiting biogen.com/privacy. Canceling this Authorization will end my consent to further disclosure of my health information to Biogen by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

Please sign in the space in Section (A) on the following page to authorize your consent.

II. Patient Services and Marketing/Other Communications Authorization

Patient Services

I authorize Biogen, and companies working with Biogen, to provide me with support services related to any of Biogen's products, including but not limited to: online support, financial assistance services, compliance and persistency and other therapy support services, as well as any information or materials related to such services. I agree and acknowledge that any nurse providing such support services is not employed by my healthcare professional. I authorize Biogen, and companies working with Biogen, to contact me to provide such services and information by mail, e-mail, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), and other mutually agreed upon means. I also authorize Biogen, and companies working with Biogen, to use my health information in connection with the services, including, without limitation, sharing such information with my healthcare provider, insurance provider, or pharmacy. I also authorize the disclosure of my health information to specific individuals that I have designated.

Marketing/Other Communications

I further authorize Biogen, and companies working with Biogen, to contact me by mail, email, fax, telephone call, and text message 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 to help develop new products, services, and programs. Note that Biogen will not sell or transfer your personal data to any unrelated third party for marketing purposes without your express permission. I understand that I may revoke this authorization and choose not to receive services or information from Biogen by mailing a letter to the address above or visiting biogen.com/privacy.

Please sign in the space in Section (B) on the following page to authorize your consent.

III. Opt-in for Automated Marketing Calls and Text Messages

I also consent to receive autodialed and prerecorded marketing calls and text messages from Biogen, and companies working with Biogen, at the telephone number(s) that I provide. 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 automated marketing calls and text messages from Biogen by mailing a letter to the address above or visiting biogen.com/privacy.

Please check the box on Section (C) on the following page to authorize your consent.

Please see accompanying full Prescribing Information and Medication Guide for additional important safety information.
This information is not intended to replace discussions with your healthcare provider.

START FORM

Phone: 1-800-456-2255 Fax: 1-800-840-1278

I. Authorization to Share Health Information

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

A Signature of patient or patient representative ____ Date ____

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

II. Patient Services and Marketing/Other Communications Authorization

I have read and understand the Patient Services and Marketing/ Other Communications Authorization and agree to the terms.

B 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 ____

C III. Marketing Opt-in

☐ I have read and understand "Opt-In to Receive Marketing Communications" and hereby agree to receive information from Biogen (optional).

____

Patient Information

☐ Male ☐ Female

Date of Birth ____

First name ____ Last name ____

Address ____

City ____ State ____ ZIP ____

Email ____

Home phone ____ ☐ Preferred number ☐ OK to leave message

Cell phone ____ ☐ Preferred number ☐ 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 *AVOSTARTGRIP® titration* kit **No Refills.** Administered IM weekly:

1/4 dose on Week 1 1/2 dose on Week 2

3/4 dose on Week 3 Full dose on Week 4.

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: Dispense:**

1 AVONEX *Administration Pack* (4 doses) or

3 *Administration Packs* (12 doses), based on plan. **Refills 12**, may supply up to 3 months at a time. **Administered:** 30 mcg IM weekly.

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)**

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

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

Pre/post treatment instructions

____

★ Training Notification

☒ I have discussed AVONEX with my patient and I believe that supplemental injection training by an AVONEX nurse educator is appropriate.

★ Medical Benefit Information

Primary insurance ____ Policy # ____

Group # ____ Insurance company phone ____

Policy holder first name ____ Policy holder 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 preferred specialty pharmacy ____

★ Statement of Medical Necessity

Primary diagnosis: ICD 9: 340/ICD 10: G35

☐ No prior disease-modifying therapies

Prior therapy

Current or most recent therapy ____ Dates on therapy ____

Other therapy ____ Dates on therapy ____

★ Prescriber Information

First name ____ Last name ____

Address ____

City ____ State ____ ZIP ____

Phone ____ Fax ____

NPI# ____ State license# ____ Tax ID# ____

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

Best time to contact: ☐ Morning ☐ Afternoon

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 9: 340/ICD 10: G35, and I will be supervising the patient's treatment accordingly.

★ Prescriber signature (Dispense as Written) ____ Date ____

★ Prescriber signature (Substitution Permitted) ____ Date ____

Signature stamps not acceptable.

†In New York, please attach copies of all prescriptions on Official New York State Prescription forms.

Instructions for **healthcare providers**

To prescribe AVONEX (interferon beta-1a), simply follow these steps:

1. **Have your patient read the Patient Consent Information and request that the patient sign the indicated areas on the accompanying Start Form.**
   Biogen takes your patient's confidentiality seriously. Signing BOTH consent lines will expedite your patient's enrollment into Biogen support services such as therapy and financial support (see Avonex.com for eligibility guidelines). In addition, with both signatures, Biogen will have access to your patient's prescription status should you or your patient need assistance.

2. **Complete the rest of the Start Form.**
   Copy both sides of the patient's insurance card and pharmacy benefit card, if available.

3. **Give your patient the Instructions for Patients and Patient Consent Information pages.**
   Then, fax the Start Form to 1-800-840-1278. Prescriptions are only valid when received via fax.

Your patient will be contacted by an AVONEX Pharmacy to arrange for delivery of the prescription.

Please be sure that all sections of the Start Form are filled out. Incomplete areas may delay the start of treatment.

WE ARE HERE TO HELP.
IF YOU HAVE ANY QUESTIONS OR WANT TO LEARN MORE ABOUT AVONEX, PLEASE CALL 1-800-456-2255 OR VISIT AVONEX.COM.

Please see accompanying full Prescribing Information for additional important safety information.

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