You and your healthcare provider chose AVONEX. Now what?

Follow these important steps:

► Fill out this AVONEX START Form with your physician and read and sign the Patient Authorization sections

► Within 2 to 3 business days, an ActiveSource® Coordinator will call you

► This call will show up as 1-800-456-2255 or 919-993-7399 on your caller ID

► If we aren’t able to reach you, your ActiveSource Coordinator will leave a message with his or her name and a toll-free phone number

You now have access to a full suite of services.

Active Access™ Ensures you can focus on treatment, not on the cost

Active Nurses™ Partners with you to provide expert guidance and training

Active Support™ Provides you with personalized, ongoing resources for education, health coaching, and emotional support

Active Voices™ Connects you and your family with others to share treatment experiences and advice

To enroll today in any of these services, simply call an ActiveSource Coordinator at 1-800-456-2255, 8:30 AM to 8:00 PM (ET).
Patient Authorization
Please read the following, and if you agree, sign and date the corresponding section on the following page.

General Authorization
I authorize Biogen Idec, the manufacturer of AVONEX, and companies working with or on behalf of Biogen Idec, to provide me with information about, or contact me to conduct market research or otherwise ask me about, my experience with or thoughts about products, services, and programs that Biogen Idec offers or sponsors or other topics that are of interest to Biogen Idec. I understand and agree that Biogen Idec, and companies working with Biogen Idec that may be unknown to me, may contact me by mail, email, and/or telephone.

Authorization of Services—Patient Support Program
I further authorize Biogen Idec, and companies working with Biogen Idec, to provide me with the therapy support services set forth on page 1 and any information or materials related to such services. I understand and agree that such services and information may be provided to me by mail, email, and/or telephone.

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy provider to disclose to Biogen Idec, and companies working with Biogen Idec, health information relating to my medical condition, treatment, and insurance coverage that is needed to provide me with the services outlined above. Once my health information has been disclosed to Biogen Idec, I understand that federal privacy laws may no longer protect the information. However, Biogen Idec agrees to protect my health information by using and disclosing it only for the purposes authorized in this Authorization or as required by law or regulations. I also authorize Biogen Idec, and companies working with Biogen Idec, 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 understand that I may refuse to sign this Authorization and choose not to receive information or services from Biogen Idec. I further understand that my treatment with a Biogen Idec product, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization.

I may cancel this Authorization at any time by mailing a letter to: Biogen Idec Patient Services, 5000 Davis Drive, P.O. Box 13919, Research Triangle Park, NC 27709-3919. Canceling this Authorization will end further disclosure of my health information to Biogen Idec and my receipt from Biogen Idec of the services, including any educational and support services, after the date Biogen Idec receives my letter, but will not affect Biogen Idec’s use of health information disclosed before receipt of my letter. Canceling this Authorization will not affect my ability to receive treatment. This Authorization expires 10 years from the day it is given.

Authorization to Share Health Information
Please read the following, and if you agree, sign and date the corresponding section on the following page.

I hereby authorize Biogen Idec and its representatives to disclose and discuss my personal health information with the individuals listed on page 3, who may act on my behalf from time to time. In addition to the individuals listed on page 3, I acknowledge that Biogen Idec may have to share my personal information with my healthcare provider and government agencies as required by law. I may cancel this Authorization or change the list of designated individuals at any time by mailing a letter expressly stating this fact to: Biogen Idec, ATTN: Patient Services, 5000 Davis Drive, P.O. Box 13919, Research Triangle Park, NC 27709-3919. Such cancellation or change in authorization shall be effective as of the date of Biogen Idec’s receipt of my letter canceling or modifying my Authorization. I understand that I may refuse to sign this Authorization and that neither my refusal to sign nor my cancellation of this Authorization will affect my ability to receive treatment with AVONEX or AVONEX Services from Biogen Idec.
### Prescriber Information

<table>
<thead>
<tr>
<th>Prescriber Last Name</th>
<th>Prescriber First Name</th>
<th>NPI #</th>
<th>Tax ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>Fax</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>Fax</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Insurance Information

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Policy #</th>
<th>Group #</th>
<th>Policy Holder Last Name</th>
<th>Policy Holder First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Telephone</td>
<td>2nd Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Time to Contact:</td>
<td>AM</td>
<td>PM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Authorization

<table>
<thead>
<tr>
<th>I have read and understand the “Patient Authorization” on page 2 and hereby agree to the terms set forth in the Authorization, including receiving the described support services and the disclosure of my health information in connection with such services.</th>
<th>Patient Signature</th>
<th>Date</th>
<th>Parent or Guardian Signature (for patients under 18 years)</th>
<th>Date</th>
</tr>
</thead>
</table>

### Authorization to Share Health Information

<table>
<thead>
<tr>
<th>I have read and understand the “Authorization to Share Health Information” on page 2 and hereby give my consent to authorize Biogen Idec to share my health information with the following designated individual(s):</th>
<th>Patient Signature</th>
<th>Date</th>
<th>Designated Individual (print name)</th>
<th>Relationship</th>
</tr>
</thead>
</table>

### Training Authorization

- **Statement of Medical Necessity**: PRIMARY DIAGNOSIS: ICD-9 CM 340

### Prescription for First Month of AVONEX with Titration

- **First Month with Titration**: Dispense: 1 AVONEX prefilled syringe Administration Pack (4 doses) with 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)

### Free Device Kit

- **Free Device Kit**: Dispense AVOSTARTGRIP™ titration kit with No Refills by Walgreens Specialty Pharmacy.

### Special Instructions

#### Ongoing Prescription for AVONEX

- **Ongoing Prescription**: 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™
    - Needle Size: 5/8” 25 Gauge Needle
    - Alternate Needle Size: Alternate size not available
  - AVONEX Prefilled Syringe
    - Needle Size: 1-1/4” 23 Gauge Needle (included in package)
    - Alternate Needle Size: 1” 25 Gauge Needle (pharmacy to provide)
  - AVONEX Lyo Vial
    - Needle Size: 1-1/4” 23 Gauge Needle (included in package)
    - Alternate Needle Size: 1” 25 Gauge Needle (pharmacy to provide)

### Prescriber Authorization*

- **Prescriber Signature** (stamps not acceptable)
  - **Date**

---

*In New York, please attach copies of all prescriptions on Official New York State Prescription forms.*
Use this form for nurse visits for current patients. If a new prescription is required, please call the patient’s current pharmacy directly.

Nurse Visit Form
Phone: 1-800-456-2255
Fax: 1-800-840-1278

**PREScriber INFORMATION**

<table>
<thead>
<tr>
<th>Prescriber Last Name</th>
<th>Prescriber First Name</th>
<th>NPI or Tax ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
</tr>
</tbody>
</table>

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>DOB: (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AVONEX Nurse Visit Services**

AVONEX injection training, follow-up instructional visits, and any additional visits requested by the patient are hereby authorized.

- **Patient’s Formulation:**
  - AVONEX® PEN™
  - AVONEX Prefilled Syringe
  - AVONEX Lyo Vial

- **Patient’s Needle Size:**
  - 5/8” 25 Gauge Needle
  - 1-1/4” 23 Gauge Needle (included in package)
  - 1” 25 Gauge Needle (pharmacy to provide)

**Special Instructions:**

- Patient’s Formulation:
  - AVONEX® PEN™
  - AVONEX Prefilled Syringe
  - AVONEX Lyo Vial

- Patient’s Needle Size:
  - 5/8” 25 Gauge Needle
  - 1-1/4” 23 Gauge Needle (included in package)
  - 1” 25 Gauge Needle (pharmacy to provide)

**PATIENT AUTHORIZATION**

**General Authorization**

I authorize Biogen Idec, the manufacturer of AVONEX, and companies working with or on behalf of Biogen Idec, to provide me with information about, or contact me to conduct market research or otherwise ask me about, my experience with or thoughts about products, services, and programs that Biogen Idec offers or sponsors or other topics that are of interest to Biogen Idec. I understand and agree that Biogen Idec, and companies working with Biogen Idec that may be unknown to me, may contact me by mail, email, and/or telephone.

**Authorization of Services—Patient Support Program**

I further authorize Biogen Idec, and companies working with Biogen Idec, to provide me with therapy support, which may include injection training, financial and reimbursement services, ongoing follow-up, and educational support, and any information or materials related to such services. I understand and agree that such services and information may be provided to me by mail, email, and/or telephone.

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy provider to disclose to Biogen Idec, and companies working with Biogen Idec, health information relating to my medical condition, treatment, and insurance coverage that is needed to provide me with the services outlined above. Once my health information has been disclosed to Biogen Idec, I understand that federal privacy laws may no longer protect the information. However, Biogen Idec agrees to protect my health information by using and disclosing it only for the purposes authorized in this Authorization or as required by law or regulations. I also authorize Biogen Idec, and companies working with Biogen Idec, 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 understand that I may refuse to sign this Authorization and choose not to receive information or services from Biogen Idec. I further understand that my treatment with a Biogen Idec product, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. I may cancel this Authorization at any time by mailing a letter to: Biogen Idec Patient Services, 5000 Davis Drive, P.O. Box 13919, Research Triangle Park, NC 27709-3919. Canceling this Authorization will end further disclosure of my health information to Biogen Idec and my receipt from Biogen Idec of the services, including any educational and support services, after the date Biogen Idec receives my letter, but will not affect Biogen Idec’s use of health information disclosed before receipt of my letter. Canceling this Authorization will not affect my ability to receive treatment. This Authorization expires 10 years from the day it is given.

- **Patient Signature or Guardian* Signature:**
- **Date:**

*Guardian signature required if patient is under 18

**PREscriber AUTHORIZATION**

I authorize Biogen Idec to provide the above-named patient with the AVONEX Nurse Services described above.

- **Healthcare Practitioner Signature:**
- **Date:**

(stamps not acceptable)