Instructions for Healthcare Providers

To prescribe TECFIDERA, please follow these steps:

1. **After discussing TECFIDERA with your patient, have your patient read the Patient Consent Information and, if interested, respond accordingly in the indicated areas on the accompanying Start Form.**
   Biogen takes your patient's confidentiality very seriously. While patients are not required to sign the Start Form in order to receive TECFIDERA, signing both lines will expedite their enrollment in **Biogen Support Services,** such as the **Biogen Copay Program** (call 1-800-456-2255 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 medical insurance card and pharmacy benefit card, if available. In some cases, the medical and pharmacy cards may be the same.
3. **Give your patient the Instructions for Patients and Patient Consent Information pages.**
   Then, fax the Start Form to 1-855-474-3067. Prescriptions are only valid when received via fax.

Your patient will be contacted by a pharmacy in the TECFIDERA Pharmacy Network to arrange for delivery of the prescription.

Please be sure to fill out all of the sections of the Start Form. Incomplete areas may delay the start of treatment.

Instructions for Patients

How do I get started?

1. **Read the Patient Consent Information and respond accordingly in Sections A, B, and C of the Start Form.**
   This will enable you to enroll in **Biogen Support Services,** such as the **Biogen Copay Program** (call 1-800-456-2255 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 TECFIDERA.
3. **Your healthcare provider fills out the rest of the Start Form.**
   You're done. Your healthcare provider will fax us the Start Form.

What happens next

- You can expect to receive several important phone calls. These calls will come from a **Biogen Support Coordinator** and a pharmacy certified to dispense TECFIDERA.
  - **You'll see 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 help you in getting started on TECFIDERA as smoothly and quickly as possible.
- Your prescription can be shipped directly to your home.

If you have any questions or want to learn more about TECFIDERA, please call 1-800-456-2255 or visit TECFIDERA.com.

Biogen
225 Binney Street
Cambridge, MA 02142
(800) 456-2255
Tecfidera.com

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

I. Authorization to Share Health Information

I understand that I have certain rights related to the collection, use, and disclosure of my medical and health information. This information is called "protected health information" (PHI) and includes demographic information (such as sex, race, date of birth, etc.), the results of physical examinations, clinical tests, blood tests, X-rays, and other diagnostic medical procedures that may be included in my medical records. Biogen will not use my PHI without my consent.

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 (i) provide me with 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, and (ii) conduct data analysis, market research and other necessary internal business activities, and (iii) provide me with information about Biogen's products, services, and programs for educational or other purposes. I understand that once I sign this Authorization, and my medical and health information is disclosed to Biogen by the Healthcare Entities, the Health Insurance Portability and Accountability Act (HIPAA) will no longer protect my information because Biogen is not covered by HIPAA. 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, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or emailing privacy@biogen.com. 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 page 4 to authorize your consent.

II. Patient Services Authorization

By signing this Authorization, 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 understand and agree that personnel including but not limited to nurses, providing such support services on behalf of Biogen are 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, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), chat, push notifications and other forms of electronic messaging.

I also authorize Biogen, and companies working with Biogen, to use and disclose my medical and health information in connection with providing the services, including but not limited to, disclosing my information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with my healthcare provider, insurance provider, or pharmacy, or disclosing my information where required by applicable laws or regulations. I also authorize the disclosure of my health information to specific individuals that I have designated.

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

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

III. Marketing Authorization

By signing this Authorization, I 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 that Biogen may use auto-dialers, prerecorded messages and artificial voice messages to contact me at the telephone number I have provided on this form and that my mobile provider may charge me to receive these messages. I understand and agree that any information that I provide may be used by Biogen to help develop new products, services, and programs. I understand that Biogen will not sell or transfer my personal information to any unrelated third party for marketing purposes without my express permission. I understand that my consent to receive marketing communications 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 services or information from Biogen by mailing a letter to the address above or sending an email with the subject "Unsubscribe" to privacy@biogen.com.

Please sign in the space in Section C on the following page 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.

START FORM

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

Tecfidera® (dimethyl fumarate) delayed-release capsules 240 mg

TEC-US-0298v17 04/23

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 Authorization

I have read and understand the *Patient Services 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):

Care partner (print name) | **Relationship**

Care partner email | **Phone**

III. Marketing Authorization

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

Signature of patient or patient representative | **Date**

Patient Information

☐ Male ☐ Female

Date of birth

First name | MI | Last name

Address

City | State | Zip

Email address

Home phone (patient) ☐ Preferred number ☐ OK to leave voicemail and/or text message

Cell phone (patient) ☐ Preferred number ☐ OK to leave voicemail and/or text message

☐ OK to leave voicemail, text message, and/or email with care partner

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

Patient preferred language

★ Medical Benefit Information

Please provide copies of front and back of all medical prescription insurance cards.

Primary insurance | Policy #

Group # | Insurance company phone

Policyholder first name | Policyholder last name

★ Pharmacy Benefit Information

Attach copies of both sides of patient's pharmacy benfit card(s).

☐ Check if no coverage ☐ Check if patient has secondary insurance

Patient's preferred specialty pharmacy

PBM name | PBM phone number

RxBin | RxPCN | Rx group # | Rx ID#

Policyholder first name | Policyholder last name

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY YOUR HEALTHCARE PROVIDER

Prescription for TECFIDERA

Month 1

☐ **Titration Starter Pack Rx for TECFIDERA:**

120 mg PO BID x7 days #14 capsules
240 mg PO BID x23 days #46 capsules
No refills

Months 2–13

Maintenance Rx for TECFIDERA:

☐ 240 mg PO BID x90 days #180 capsules 3 refills
☐ 240 mg PO BID x30 days #60 capsules 11 refills

See below or attached for Healthcare Provider Instructions:

★ Statement of Medical Necessity

ICD 10: G35

Primary diagnosis

Current or most recent therapy:

☐ No prior disease-modifying therapies

Allergies:

☐ No Known Drug Allergies (NKDA)

Height: inches/cm | Weight: lbs/kg | Date height/weight taken

Prescriber Information

First name | Last name | Phone | Fax

Address | City | State | Zip

Email | Tax ID # | NPI #

Clinical/Hospital affiliation | Office contact name | Prescriber State License #

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 TECFIDERA therapy is for a primary diagnosis of ICD-10: G35, and I will be supervising the patient's treatment accordingly.

★ X | ★

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

Prescriber signature (substitution permitted). Signature stamps not acceptable. | **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 prescriptions form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.