plegridy
(peginterferon beta-1a)
125 mcg INJECTION

Instructions for Healthcare Providers

PLG-US-1201 v3 11/24

To prescribe PLEGRIDY® (peginterferon beta-1a), please follow these steps:

1. **After discussing PLEGRIDY with your patient, have your patient read the Patient Consent Information on pages 2-3 and, if interested, respond accordingly 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 PLEGRIDY, signing these 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 these 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 guides.**
   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 PLEGRIDY 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 on pages 2-3 and respond accordingly in Sections A, B, C, and D 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 on page 4.**
   By giving us your email address, you can stay up to date on the latest news about PLEGRIDY.

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 PLEGRIDY.
  - **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 PLEGRIDY 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 PLEGRIDY, please call 1-800-456-2255 or visit PLEGRIDY.com.

Biogen
225 Binney Street
Cambridge, MA 02142
1-800-456-2255
PLEGRIDY.com

Patient Consent Information

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

Continued on following page.

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 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 programs, and (iii) I agree to notify Biogen immediately if I obtain a federally-funded insurance plan during my enrollment in certain Biogen program(s) 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

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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):

Designated individual (print name) | Relationship

Designated individual email | Phone

III. Marketing Authorization

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

C

Signature of patient or patient representative | Date

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

IV. Government Payer Attestation

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

D

☐ 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.

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY YOUR HEALTHCARE PROVIDER

Prescription Information

Please check appropriate boxes to indicate prescription and medication delivery

First Month of PLEGRIDY® with Titration (Select One):

☐ Dispense PLEGRIDY SUBCUTANEOUS Pen Starter Pack *(NDC 64406-012-01)*

☐ Dispense PLEGRIDY SUBCUTANEOUS Prefilled Syringe Starter Pack *(NDC 64406-016-01)*

☐ Dispense PLEGRIDY INTRAMUSCULAR Prefilled Syringe Administration Kit *(NDC 64406-017-01)*; Dispense PLEGRIDY INTRAMUSCULAR Titration Kit (contains titration clips ONLY) through Walgreens Specialty Pharmacy® *(No NDC)*

Refills: 0

Administered: 1/2 dose (63 mcg) on Day 1
3/4 dose (94 mcg) on Day 15

Ongoing Prescription for PLEGRIDY (Select One Administration Device):

☐ PLEGRIDY SUBCUTANEOUS Pen *(NDC 64406-011-01)*

☐ PLEGRIDY SUBCUTANEOUS Prefilled Syringe *(NDC 64406-015-01)*

☐ PLEGRIDY INTRAMUSCULAR Prefilled Syringe *(NDC 64406-017-01)*

Based on Plan, Dispense:

☐ 1 PLEGRIDY Administration Kit (2 doses)

☐ 3 PLEGRIDY Administration Kits (6 doses), based on plan

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

Administered: 125 mcg every 14 days

Pre-/Post-treatment Instructions

Training Notification

☒ I have discussed PLEGRIDY and its use with my patient and I believe that supplemental injection training by a PLEGRIDY Nurse Educator is appropriate.

Medical Benefit Information

Primary insurance | Policy #

Group # | Insurance company phone

Policyholder first name | Policyholder last name

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

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

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 PLEGRIDY 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.