Aduhelm™
(aducanumab-avwa)

Access Program Enrollment Form

As part of Biogen's commitment to offering access and reimbursement support and preventing treatment delays, the **ADUHELM Access Program** will help temporarily provide ADUHELM at no cost to your facility or your patients.*

Instructions for healthcare providers

1. After discussing treatment with ADUHELM and the temporary **ADUHELM Access Program**, have your patient read the **Patient Consent Information**. If he or she is interested, confirm that he or she has signed and completed the indicated patient sections of this form.
2. Complete the indicated **Healthcare Provider Section** of this form.
3. Give your patient the **Patient Consent Information** page. Note: If patient requests, please provide a copy of the completed form for them to keep.
4. Fax the completed form (page 3) and valid prescription to **1-855-474-3067** (separate prescription not required if prescription and prescriber information are included on page 3).

*Available only until the earlier of (1) a permanent J-code is available or (2) the site is able to obtain ADUHELM for the patient through a buy-and-bill or specialty pharmacy route. This program does not cover the potential cost of administration, or other costs associated with treatment, such as magnetic resonance imaging monitoring or diagnostic testing. Please note that the drug provided under this program is patient-specific and cannot be used for alternative patients. Sites are not permitted to seek reimbursement from insurance companies or to file claims with any third-party payer including Medicare or Medicaid for drug provided under this program.

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Patient Consent Information

Please read the following. If you agree, complete, sign, and date the corresponding sections below.

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 (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 support services, (ii) conduct data analysis, market research and other internal business activities, and (iii) provide me with 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 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 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.

If you are a California resident, California law provides you with additional rights regarding our collection and use of your personal information. This includes providing you with information about the categories of personal information that we collect and how we use it, described in more detail at: https://www.biogen.com/en_us/california-policy.html

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 B 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 support services, as well as any information or materials related to such services. I agree and authorize 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, email, 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. 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 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. For more information visit biogen.com/privacy.

Please sign in the space in Section C 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 in Section D to authorize your consent.

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY THE PATIENT

A Patient Information

*Required Fields

First Name* | Last Name*

Date of Birth* | ☐ Male* ☐ Female*

Address*

City* | State* | ZIP Code*

Email Address*

Phone Number*

Best Time to Contact:
- ☐ Morning
- ☐ Afternoon
- ☐ Evening

☐ OK to leave message

Patient Preferred Language

B 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's legal representative | Date

*If signed by legal representative, by my signature above I represent and warrant that I have current legal authority to execute on behalf of the patient.

Please explain authority to act on behalf of the patient.*

C 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.

Signature of patient or patient's legal representative | Date

*If signed by legal representative, by my signature above I represent and warrant that I have current legal authority to execute, authorize and attest below on behalf of the patient.

Authorizing a Caregiver (optional)

By providing Caregiver information below, I authorize the disclosure of my health information to the following designated individual (optional).

☐ I also authorize this individual to take action on my behalf for the purposes of assessing my eligibility and enrolling me in Biogen services. I attest that the individual designated below has my permission and the knowledge and ability to accurately provide information about my insurance plans as well as provide details regarding my financial status.

Caregiver First Name | Caregiver Last Name | Relationship

Address

City | State | ZIP Code

Caregiver Email | Caregiver Phone

*By providing the Caregiver information above, I confirm that I have received permission from the designated individual listed above to share their contact information with Biogen.

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

☐ I have read and understand the *Opt-in for Automated Marketing Calls and Text Messages* and hereby agree to receive such information from Biogen (optional).

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225 Binney Street, Cambridge, MA 02142
(833) 425-9360 | ADUHELM.com

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THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY A HEALTHCARE PROVIDER

- ☐ Patient has confirmed amyloid beta biomarker pathology.
- ☐ Patient has been diagnosed with Alzheimer's disease in the mild cognitive impairment (MCI) or mild dementia clinical stage.
- ☐ I understand and agree to abide by the rules and conditions of the ADUHELM™ (aducanumab-avwa) Access Program.

Healthcare Provider Signature | Date

Print Healthcare Provider Name

Treatment Site Contact Information

Please note that the ADUHELM provided under the program will be shipped to the address specified here.

Site Name | Office Contact Name

Address

City | State | ZIP Code

Phone | Fax | Prescriber NPI

Prescription and Prescriber Information (optional)

Treatment sites may either have a prescriber complete the prescription and prescriber information sections, OR fax a separate valid prescription along with the rest of the completed form.

***Required fields if separate prescription is not provided.**

Patient weight _____ kg

Dosing

☐ ADUHELM prescription.

ADUHELM is dosed based on the patient's actual weight. Patient's weight should be recorded before each infusion and used to calculate the dose based on the recommended schedule.

Please refer to the dosing schedule provided in section 2.0 of the full Prescribing Information

Titrated Dosing

- ☐ 1 mg/kg dose administered as 2 separate IV infusions 4 weeks apart
- ☐ 3 mg/kg dose administered as 2 separate IV infusions 4 weeks apart
- ☐ 6 mg/kg dose administered as 2 separate IV infusions 4 weeks apart

Maintenance Dosing

10 mg/kg dose administered as _____ separate IV infusions 4 weeks apart

Notes _____

Prescriber Signature* | Date*

Prescriber Information

First Name* | Last Name*

Phone Number*: 215-957-9250 | Fax*: 215-957-9254

Email Address*

Prescriber NPI* | State License #*

DEA #* | Tax ID #*

Please fax the completed form (page 3) and valid prescription to 1-855-474-3067
(separate prescription not required if prescription and prescriber information are included on page 3).

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