Instructions for **Patients**

plegridy® (peginterferon beta-1a)

06/18 PLG-US-0160 v5

How do I get started?

1. **Read the Patient Consent Information and sign as indicated in the blue box on 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 PLEGRIDY.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 PLEGRIDY®.
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 an Above MS Support Coordinator and an authorized PLEGRIDY Specialty Pharmacy Representative.

— 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 get started on PLEGRIDY as smoothly and quickly as possible.

Your prescription can be shipped directly to your home.

Support is here if you need it through Biogen's Above MS services

For those who qualify, insurance and financial assistance support is available, including the $0 Copay Program for eligible patients. Visit PLEGRIDY.com for enrollment details.

Above MS Nurse Educators are there to provide additional support to you and your care partner with injection technique and to respond to questions you may have. They are available by phone 24 hours a day, 7 days a week.

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

Indication

PLEGRIDY® (peginterferon beta-1a) is a prescription medicine used to treat people with relapsing forms of multiple sclerosis (MS).

Important Safety Information

Before beginning treatment, you should discuss with your healthcare provider the potential benefits and risks associated with PLEGRIDY.

PLEGRIDY can cause serious side effects. Call your healthcare provider right away if you have any of the symptoms listed below.

- Liver problems, or worsening of liver problems including liver failure and death. Symptoms may include yellowing of your skin or the white part of your eye, nausea, loss of appetite, tiredness, bleeding more easily than normal, confusion, sleepiness, dark colored urine, and pale stools. During your treatment with PLEGRIDY you will need to see your healthcare provider regularly. You will have regular blood tests to check for these possible side effects
- Depression or suicidal thoughts. Symptoms may include new or worsening depression (feeling hopeless or bad about yourself), thoughts of hurting yourself or suicide, irritability (getting upset easily), nervousness, or new or worsening anxiety

Do not take PLEGRIDY if you are allergic to interferon beta or peginterferon beta-1a, or any of the other ingredients in PLEGRIDY.

Before taking PLEGRIDY, tell your healthcare provider if you:

- Are being treated for a mental illness or had treatment in the past for any mental illness, including depression and suicidal behavior
- Have or had liver problems, low blood cell counts, bleeding problems, heart problems, seizures (epilepsy), thyroid problems, or any kind of autoimmune disease
- Take prescription and over-the-counter medicines, vitamins, and herbal supplements
- Are pregnant or plan to become pregnant. It is not known if PLEGRIDY will harm your unborn baby. Tell your healthcare provider if you become pregnant during your treatment with PLEGRIDY
- Are breastfeeding or plan to breastfeed. It is not known if PLEGRIDY passes into your breast milk. Talk to your healthcare provider about the best way to feed your baby if you use PLEGRIDY

Please see full Prescribing Information and Medication Guide starting on page 5 for additional important safety information. This information is not intended to replace discussions with your healthcare provider.

PLEGRIDY can cause additional serious side effects including:

- **Serious allergic reactions.** Serious allergic reactions can happen quickly. Symptoms may include itching, swelling of the face, eyes, lips, tongue, or throat, trouble breathing, feeling faint, anxiousness, skin rash, hives, or skin bumps
- **Injection site reactions.** PLEGRIDY may commonly cause redness, pain or swelling at the place where the injection was given. Call your healthcare provider right away if an injection site becomes swollen and painful or the area looks infected and it does not heal within a few days. You may have a skin infection or an area of severe skin damage (necrosis) requiring treatment by a healthcare provider
- **Heart problems, including congestive heart failure.** While PLEGRIDY is not known to have any direct effects on the heart, some people who did not have a history of heart problems developed heart muscle problems or congestive heart failure after taking interferon beta. If you already have heart failure, PLEGRIDY may cause your heart failure to get worse. Call your healthcare provider right away if you have worsening symptoms of heart failure such as shortness of breath or swelling of your lower legs or feet while using PLEGRIDY
  - Some people using PLEGRIDY may have other heart problems, including low blood pressure, fast or abnormal heart beat, chest pain, heart attack, or a heart muscle problem (cardiomyopathy)
- **Autoimmune diseases.** Problems with easy bleeding or bruising (idiopathic thrombocytopenia), thyroid gland problems (hyperthyroidism and hypothyroidism), and autoimmune hepatitis have happened in some people who use interferon beta
- **Blood problems and changes in your blood tests.** PLEGRIDY can decrease your white blood cells or platelets, which can cause an increased risk of infection, bleeding or anemia, and can cause changes in your liver function tests. Your healthcare provider should do blood tests while you use PLEGRIDY to check for side effects
- **Seizures.** Some people have had seizures while taking PLEGRIDY, including people who have never had seizures before

The most common side effects of PLEGRIDY include:

- **Flu-like symptoms.** Many people who take PLEGRIDY have flu-like symptoms early in the course of therapy. These symptoms are not really the flu. You cannot pass it on to anyone else. **Symptoms may include** headache, muscle and joint aches, fever, chills or tiredness
  - You may be able to manage these flu-like symptoms by taking over-the-counter pain and fever reducers and drinking plenty of water. For many people, these symptoms lessen or go away over time

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

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, e-mail, 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 in Section C on the following page to authorize your consent.

Please see Important Safety Information on page 1 and full Prescribing Information and Medication Guide starting on page 5.

START FORM

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

Indicates required information

plegridy (peginterferon beta-1a)

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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 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

Designated individual email | Phone

III. Marketing Opt-in

C ☐ I have read and understand Opt-in Automated Marketing Calls and Text Messages 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

Patient's preferred language

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY YOUR HEALTHCARE PROVIDER

Prescription Information

☑ PLEGRIDY Pen ☐ PLEGRIDY Prefilled Syringe

Starter Pack (first month)*

☒ Starter Pack Rx for PLEGRIDY
Day 1: inject 63 mcg
Day 15: inject 94 mcg
(No refills.) ***Administered:*** *subcutaneously*

Pen: NDC 64406-012-01
Prefilled Syringe: NDC 64406-016-01

Maintenance Rx (months 2–13)

☒ Inject 125 mcg every 14 days
(May dispense 90 days at a time.)
Administered: *subcutaneously*

Pen: NDC 64406-011-01
Prefilled Syringe: NDC 64406-015-01

*If your patient is already on PLEGRIDY and does not need to titrate, please cross out this option and note "no titration" in the Pre/Post-treatment Instructions section.

Refills x 1 year (dispense all supplies necessary for administration)

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 therapies: Current or most recent therapy | Dates on therapy

Other therapy | Dates on therapy

Height: inches/cm | Weight: lbs/kg | 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 (substitution permitted). Signature stamps not acceptable. | Date

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

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

Instructions for **Healthcare Providers**

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 and, if interested, sign the indicated areas on the accompanying Start Form.**
Biogen takes your patient's confidentiality seriously. While patients are not required to sign the Start Form in order to receive PLEGRIDY, signing both lines will expedite their enrollment in the Above MS™ program from Biogen, which provides support services such as the **$0 Copay Program** (see PlegridyHCP.com for eligibility guidelines). In addition, with both signatures Biogen can access 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 PLEGRIDY Pharmacy Network 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 PLEGRIDY, please call 1-800-456-2255 or visit PlegridyHCP.com.

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Please see full Prescribing Information starting on page 5.