START FORM

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

VUMERITY® (diroximel fumarate) delayed-release capsules 231 mg

VUM-US-0010 v7 06/21

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):

Care partner (print name) | Relationship

Care partner email | Phone

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

C

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

Patient Information

☐ Male ☐ Female

First name | Last name

Address

City | State | Zip

Date of birth | 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

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

Patient's preferred language

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY YOUR HEALTHCARE PROVIDER

Prescription for VUMERITY

Month 1

☐ **Titration Rx for VUMERITY:**

231 mg x 1 PO BID	x7 days	#14 capsules
462 mg (231 mg x 2) PO BID	x23 days	#92 capsules

No refills

Months 2-13

Maintenance Rx for VUMERITY:

☐ 462 mg (231 mg x 2) PO BID	x90 days	#360 capsules	3 refills
☐ 462 mg (231 mg x 2) PO BID	x30 days	#120 capsules	11 refills

See below or attached for Healthcare Provider Instructions:

Statement of Medical Necessity

Primary diagnosis: ICD-10: G35

Current or most recent therapy | Dates/Duration

Other therapy
☐ No prior disease-modifying therapies

Height: inches/cm | Weight: lbs/kg | Allergies

QuickStart Program (Optional, at no cost to patient; for commercially insured patients only*)

☐ Yes, I authorize Biogen to provide up to 4 months of VUMERITY to my patient at no cost (one Titration Rx and ongoing Maintenance Rx, as needed) until the patient's prescription coverage is secured. I authorize Biogen to forward this prescription to the QuickStart Program designated pharmacy to dispense VUMERITY directly to the above-named patient. Patient signatures are needed for (A) and (B) above to expedite enrollment in the QuickStart Program.

*Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®, and other governmental insurance are NOT eligible for this program. TRICARE® is a registered trademark of the Department of Defense, DHA. All rights reserved.

QuickStart Rx for VUMERITY:

Titration Rx

231 mg x 1 PO BID	x7 days	#14 capsules
462 mg (231 mg x 2) PO BID	x7 days	#28 capsules

Maintenance Rx

462 mg (231 mg x 2) PO BID	x14 days	#56 capsules	7 refills

Prescriber Information

First name | Last name

Address

City | State | Zip

Phone | Fax

NPI # | Tax ID #

Clinical/Hospital affiliation | Office contact name

★ Medical Benefit Information

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 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 VUMERITY 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.

Please see Important Safety Information on page 2 and accompanying full Prescribing Information, including Patient Information.