Biogen Support Services Request Form

BIOGEN SUPPORT SERVICES FOR PATIENTS

06/21 ADU-US-0759

INSTRUCTIONS FOR PATIENTS

Biogen Support Services offers eligible patients assistance to get started and stay on ADUHELM™ (aducanumab-avwa). These services may include help with understanding out-of-pocket costs, financial assistance for eligible patients, and finding specialists, treatment sites, and diagnostic and imaging facilities.

To speak with a Biogen representative about the resources that may be available to you, call **1-833-425-9360; Mon-Fri, 8:30 AM – 10 PM EST & Sat, 8:30 AM – 5 PM EST**.

1. After discussing **Biogen Support Services** with your healthcare provider, read the Patient Consent Information on page 2.
2. To get started, fill out the green section of the form on page 3. Your healthcare provider will send it to Biogen and **Biogen Support Services** will contact you soon.

   Biogen takes patient confidentiality very seriously. Signing this consent form will allow Biogen to provide support services that may require use of your personal health information.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

This form provides information to **Biogen Support Services for Patients**, who will reach out to patients to assess their support service needs and provide information about available offerings. Once completed, please fax to **1-855-474-3067**.

1. To get started, have your patient read the Patient Consent Information. If they express an interest in **Biogen Support Services for Patients**, have them fill out and sign the patient section of the form on page 3.
2. Complete the Healthcare Provider portion on page 3. Copy both sides of the patient's medical insurance card and pharmacy benefit card (optional).
3. Fax the completed form to **1-855-474-3067**. Then give your patient the Instructions for Patients and Patient Consent Information pages. **Biogen Support Services for Patients** will contact your patient soon.

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

Patient Consent Information

BIOGEN SUPPORT SERVICES FOR PATIENTS

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Please read the following. If you agree, complete, 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 (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: **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 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 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 provider. 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 B on the following page to authorize your consent.

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

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.

Please check the box in Section C on the following page to authorize your consent.

Questions?
Contact a Biogen Representative at 1-833-425-9360

BIOGEN SUPPORT SERVICES FOR PATIENTS

★ Indicates required information

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THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE PATIENT

A 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 _____

B 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.

C 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).

★ Patient Information

☐ Male ☐ Female

First Name _____ Last Name _____

Date of Birth _____

★ Patient Contact Information

Address _____

City _____ State _____ ZIP Code _____

Email Address _____

Phone Number (at least 1 number is required below)

Home Telephone _____ ☐ Preferred Number ☐ OK to leave message

Mobile Telephone _____ ☐ Preferred Number ☐ OK to leave message

Best Time to Contact:

☐ Morning ☐ Afternoon ☐ Evening

Patient Preferred Language _____

THE FOLLOWING SECTION SHOULD BE FILLED OUT BY A HEALTHCARE PROVIDER

★ Does the patient have confirmed amyloid beta pathology?

☐ Yes ☐ No

★ Prescriber Information

First Name _____ Last Name _____

Address _____

City _____ State _____ ZIP Code _____

Phone _____ Fax _____ Prescriber NPI _____

Medical Insurance Information (optional)

Attach copies of insurance card(s): Please remember to include front and back copy of insurance card(s) along with this Biogen Support Services Form.

Treatment Site Information (optional)

Site Name _____ Office Contact Name _____

Address _____

City _____ State _____ ZIP Code _____

Phone _____ Fax _____

How does your site intend to procure therapy? (optional)

☐ Buy-and-Bill (Site Purchase)

☐ Specialty Pharmacy (Patient Purchase)

Name of Specialty Pharmacy (if applicable) _____

PROVIDERS: Please fax the completed form to 1-855-474-3067.