SPINRAZA®
(nusinersen) injection
12 mg/5 mL

STARTING SPINRAZA

How to begin treatment with SPINRAZA and enroll in Biogen Support Services

For information about SPINRAZA, visit SPINRAZAHCP.com.

For all other information, contact your Biogen Rare Disease Account Executive at 1-844-4SPINRAZA (1-844-477-4672).

Biogen

225 Binney Street, Cambridge, MA 02142

SPINRAZA® (nusinersen) injection 12 mg/5 mL

INSTRUCTIONS FOR PATIENTS OR CAREGIVERS

How to begin treatment with SPINRAZA® and enroll in Biogen Support Services:

Follow these steps to start your SPINRAZA treatment journey and to enroll in eligible Biogen Support Services.
Please note: Incomplete forms may delay access to Biogen services.

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1 Complete the Patient Consent Pages

First, read the Consent Information on the following pages.

- **Sign your name** if you agree to all 3 Authorizations in Sections A, B, and C of the Patient Consent pages. If you can't be present to sign the Patient Consent pages in person, you can ask your healthcare provider to send it via **DocuSign**

Additionally, your doctor will need to complete the Healthcare Provider portion of your form. When you have finished filling in your information and signing, please notify your doctor so they can complete the process.

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2 Meet your SPINRAZA team

After the Patient Consent Pages and Healthcare Provider Start Form have been submitted to Biogen, the person receiving treatment will be enrolled in Biogen Support Services if eligible.

Your Family Access Manager (FAM) or **Lead Case Manager (LCM)** will be calling you. Your dedicated SPINRAZA care team will be there to help you and your family throughout the treatment journey. You will be guided step by step through the process, including a face-to-face meeting with your FAM. This meeting is optional and may occur at a location of your choice.

- Your LCM can also be reached at **1-844-4SPINRAZA (1-844-477-4672)**, Monday through Friday, from 8:30 AM to 8:00 PM ET
- If you have caller ID on your telephone, you may see a call from a 1-919 number, or a call that says "Unknown." Calls made to you from a Biogen employee's personal home phone may indicate "Unknown" for privacy reasons

Your FAM may be able to help with treatment logistics and information about the treatment center, and if needed, an orientation at the center where the first dose of SPINRAZA will be administered.

- Before starting treatment on SPINRAZA and before each dose, lab tests are required to monitor for risk of bleeding and kidney damage

Biogen Support Services provides certain services that your FAM will help you enroll in. These services address nonmedical barriers to access that include logistical assistance, product education, insurance benefits investigations, and financial assistance. A complete list of the Biogen Support Services offerings can be found at **SPINRAZA.com/support**.

QUESTIONS? Talk to your healthcare provider or call 1-844-4SPINRAZA (1-844-477-4672)

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CONSENT INFORMATION FOR PATIENTS OR CAREGIVERS

Please read all 3 authorizations. If you agree, please sign and date below each section.

**Required fields*

I. Authorization to Share Health Information

I understand that I have certain rights related to the collection, use, and disclosure of [my/my child's] 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/my child's] medical records. Biogen will not use [my/my child's] PHI without my consent.

By signing this Authorization, I authorize [my/my child's] healthcare provider, [my/my child's] health insurance company and [my/my child's] pharmacy providers ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), health information relating to [my/my child's] medical condition, treatment, and insurance coverage for Biogen to (i) provide [me/my child] 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/my child's] 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/my child's] 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/my child's] pharmacy provider may receive remuneration from Biogen in exchange for the health information and/or for any therapy support services provided to [me/my child].

I understand that I may refuse to sign this Authorization. I further understand that [my/my child's] 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/my child] 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/my child's] health information to Biogen by [my/my child's] 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/my child's] ability to receive treatment, payment for treatment, or [my/my child's] 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.

A 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 representative*

**Date*

SPINRAZA® (nusinersen) injection 12 mg/5 mL

CONSENT INFORMATION FOR PATIENTS OR CAREGIVERS

II. Patient Services Authorization

By signing this Authorization, I authorize Biogen, and companies working with Biogen, to provide [me/my child] 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/my child's] 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/my child's] medical and health information in connection with providing the services, including but not limited to, disclosing [my/my child's] information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with [my/my child's] healthcare provider, insurance provider, or pharmacy, or disclosing [my/my child's] information where required by applicable laws or regulations. I also authorize the disclosure of [my/my child's] health information to specific individuals that I have designated.

B PATIENT SERVICES AUTHORIZATION

I have read and understand the Patient Services Authorization and agree to the terms.

**Signature of patient or patient representative*

**Date*

In addition, I authorize the disclosure of my health information to the following designated individual(s) (optional):

Name (print) *Relationship*

Name (print) *Relationship*

III. Marketing Authorization (OPTIONAL)

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 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/my child's] experience with or thoughts about such topics. I understand that Biogen may use auto-dialers, prerecorded messages and artificial voice messages to contact me at the telephone number I have provided on this form and that my mobile provider may charge me to receive these messages. I understand and agree that any information that I provide may be used by Biogen for marketing purposes, including targeted online marketing, as well as to help develop new products, services, and programs. I understand that Biogen will not sell or transfer [my/my child's] personal information to any unrelated third party for marketing purposes without my express permission. I understand that my consent to receive marketing communications 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, [clicking the "Unsubscribe" link at the bottom of this page], 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**.

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

C

Signature of patient or patient representative *Date*

Residents of certain US States (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your 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**.

SPINRAZA® (nusinersen) injection 12 mg/5 mL

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

Once the Patient Consent Pages and Healthcare Provider Start Form have all required fields filled in and signed, they can be submitted to Biogen in one of the following ways:

Print, **fill out**, and **fax** to 1-888-538-9781

OR

Fill out and **email** as an **attachment** to **StartForm@biogen.com**

If you are unable to sign in person or would rather sign electronically, please send this form via DocuSign.

If you have any questions, please call 1-844-4SPINRAZA (1-844-477-4672)

To help your patients enroll in Biogen Support Services or begin SPINRAZA treatment, please follow these steps:

1. Discuss the benefits and risks of treatment, then ask the patient or parent/guardian to read pages and sign the Patient Consent pages. Delays in gathering patient consent may impact timely enrollment of patients in support services.
   - If a patient isn't able to sign these pages in person, you may send them to the patient via **DocuSign**
2. Complete the Healthcare Provider section of the Start Form. Incomplete forms may delay access to Biogen services. If you can't be present to fill out and sign the Start Form in person, you can use **DocuSign**.
   - **Specialty Pharmacy:** Fill out the Prescription section of the Start Form (*optional*). Submitting the Start Form will enroll your patients in Biogen Support Services and a prescription will be filled by the specialty pharmacy
   - **Direct Buy:** Follow your usual office procedure for procuring medication. Submitting the Start Form will only enroll your patients in Biogen Support Services
   - **Unknown:** If your procurement methodology is unknown, please check the corresponding box and Biogen will follow up with you
3. Please make a photocopy of both sides of the covered individual's insurance card and pharmacy benefit card, if available.
4. Send the completed Patient Consent pages and Start Form and copies of insurance card and pharmacy benefit card to Biogen.
   - Fax to **1-888-538-9781** or email as an attachment to **StartForm@biogen.com** (this email address is an unattended inbox and is for Start Forms only). For questions, please contact your Biogen Rare Disease Account Executive, or call **1-844-477-4672**

Once the Patient Consent Pages and Start Form have been received by Biogen, the patient or caregiver will be contacted by a SPINRAZA Family Access Manager (FAM) or Lead Case Manager (LCM) to help navigate the process.

Biogen takes the confidentiality of personal information seriously. The benefits of granting consent include:

- Expediting enrollment into Biogen Support Services, which includes help in areas such as treatment logistics, insurance, and financial assistance
- Giving Biogen access to the status of your prescription should assistance be required

HEALTHCARE PROVIDER START FORM

All information must be completed by a healthcare provider for patient to receive Biogen services.

*Required fields

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PATIENT INFORMATION

☐ Male ☐ Female ☐ Prefer not to respond

My pronouns are: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs other: _____

*First name | M.I. | *Last name

My preferred language

*Date of birth

CONTACT INFORMATION

☐ Okay to leave message

*Email address

*Primary phone | Other phone

*Address

*City | *State | *ZIP code

PRESCRIBER INFORMATION

*First name | *Last name

*Address

*City | *State | *ZIP code

*Telephone | Fax

*Email

NPI # | State license #

Tax ID # | Clinic/hospital affiliation

ADMINISTERING PHYSICIAN INFORMATION

☐ Select if same as Prescriber Information

First name | Last name

Specialty | Care coordinator contact

Telephone | Fax

NPI # | Tax ID #

TREATMENT

Prior/current treatment (medication)
Check all that apply:

☐ Evrysdi® ☐ Zolgensma® ☐ SPINRAZA®

Next scheduled SPINRAZA dose (if known)

Date

Concurrent medications: _____

SITE OF CARE

☐ Select if you are unsure of site of care. The Biogen team will help you and your patient identify an appropriate site.

Facility name

Address

City | State | ZIP code

Telephone | Fax

NPI # | Tax ID #

PROCUREMENT

☐ Specialty pharmacy—*optional prescription below*

☐ Direct buy—*order must be submitted*

☐ Unknown

PLACE OF SERVICE (POS) CODE

☐ Physician office (11)

☐ Outpatient off-campus clinic (19)

☐ Inpatient (21) Observation a possibility in lieu of inpatient admission? Yes ☐ No ☐

☐ Outpatient on campus (ie, infusion, short stay, surgical suite) (22)

☐ Ambulatory surgical center (24)

☐ Other _____

MEDICAL INSURANCE INFORMATION

Disease type: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Genetic test on file ICD-10 code: _____

Primary insurance | Policy #

Secondary insurance | Policy #/ Group #

Group # | Insurance company telephone

Medicaid/governmental payer

Policyholder's first name | Policyholder's last name

Please note: Include front and back copy of insurance card(s) along with this Start Form.

PRESCRIBER AUTHORIZATION (REQUIRED)

I authorize Biogen as my designated agent on behalf of my patient to furnish any information on this form to his/her insurer. I certify the rationale for prescribing SPINRAZA for this patient and will supervise treatment accordingly.

*Prescriber signature | *Date

Once complete, submit by fax or email:
1-888-538-9781
StartForm@biogen.com

PRESCRIPTION FOR SPECIALTY PHARMACY (OPTIONAL)†

Inject SPINRAZA treatment with 4 loading doses. The 1st 3 loading doses should be administered at 14-day intervals. The 4th dose should be administered 30 days after the 3rd dose. A maintenance dose should be administered every 4 months. For more information, please refer to the Prescribing Information.

SPINRAZA (nusinersen) injection 12 mg/5 mL (2.4 mg/mL) in a single-dose vial:

☐ Loading doses (4 doses) ☐ 1 year of SPINRAZA with maintenance doses (3 doses) ☐ 1 year of SPINRAZA with loading doses (6 doses) Refills _____

Name (print) | Prescriber signature (dispense as written) | Prescriber signature (substitution allowed) | Date

I authorize Biogen as my designated agent and on behalf of my patient to forward the above prescription by fax or other mode of delivery, to the pharmacy chosen by the above-named patient.

†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.