



Instructions and Start Forms for the

HIGH DOSE REGIMEN

This Start Form is for the High Dose Regimen. To prescribe the Low Dose Regimen, please use the corresponding [Start Form](#).

For information about SPINRAZA, visit [SPINRAZAHCP.com](https://www.spinrazahcp.com).

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

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225 Binney Street, Cambridge, MA 02142



Instructions and consent information for patients or caregivers



Please note: Incomplete forms may delay access to Biogen services.

To begin treatment with SPINRAZA® (nusinersen) and enroll in Biogen Support Services, read and complete the Patient Consent Authorizations below and on the following page.

Please read all 3 authorizations. If you agree, please sign and date below each section. 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](#). When you have finished completing the Patient Consent Pages, notify your doctor so they can complete the Healthcare Provider form.

QUESTIONS?

Talk to your Family Access Manager, healthcare provider, or call 1-844-4SPINRAZA (1-844-477-4672)

**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 (i) Biogen to 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/my child's 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/my child's 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, Morrisville, NC, 27650 or emailing privacy@biogen.com. Canceling this Authorization will end my/my child's 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/my child's 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. I understand I have a right to receive a copy of this form.

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*

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 further authorize Biogen to use my personal information to access my credit profile, including but not limited to, information from a consumer reporting agency (credit bureau) and information derived from public and other sources to estimate my income as part of the determination of eligibility for financial assistance. I also authorize the disclosure of my/my child's health information to specific individuals that I have designated.

PATIENT SERVICES AUTHORIZATION

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

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

**Signature of patient or patient representative*

Name (print)

Relationship

**Date*

Name (print)

Relationship

III. Marketing Authorization (Optional)

By signing this Authorization, I 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/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 services or information from Biogen by sending an email with the subject "Unsubscribe" to privacy@biogen.com, or mailing a letter to Biogen, 5000 Davis Drive, Morrisville, NC 27560. For more information visit biogen.com/privacy.

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

**Signature of patient or patient representative*

**Date*

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

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, Morrisville, NC 27560 or emailing privacy@biogen.com.

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 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](#).**
- 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 with 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. Biogen provides the following support services:

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

Healthcare Provider Start Form



All information on this page must be completed by a healthcare provider in order for a patient to receive Biogen services. Start Form applies to the High Dose Regimen. For the Low Dose Regimen Start Form, visit SpinrazaHCP.com.

***Required fields**

PATIENT INFORMATION

Male Female Prefer not to respond

Patient's pronouns are:

she/her/hers he/him/his they/them/theirs other _____

*First name _____ M.I. _____ *Last name _____

Patient's preferred language _____

*Date of birth _____

PRESCRIBER INFORMATION

*First name _____ *Last name _____

*Address _____ *City _____

*Telephone _____ *State _____ *ZIP code _____

*Email _____ Fax _____

NPI # _____ State license # _____

Tax ID # _____ Clinic/hospital affiliation _____

MEDICAL INSURANCE INFORMATION

ICD-10 code:

Disease type: 1 2 3 4 Genetic test on file

Primary insurance _____ Policy # _____

Group # _____ Insurance company telephone _____

Policyholder's first name _____ Policyholder's last name _____

Secondary insurance _____ Policy # / Group # _____

Medicaid/governmental payer Check here if uninsured

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

PRIOR TREATMENT

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

Evrysdi Zolgensma SPINRAZA® Low Dose Regimen Muscle Enhancer(s)
 Ivisma None

Date of last SPINRAZA injection (if known) _____ Concurrent medications _____

CONTACT INFORMATION

Okay to leave message

*Email address _____

*Primary phone _____ Other phone _____

*Address _____

*City _____ *State _____ *ZIP code _____

ADMINISTERING PHYSICIAN INFORMATION

Select if same as Prescriber Information

First name _____ Last name _____

Specialty _____ Care coordinator contact _____

Telephone _____ Fax _____

NPI # _____ Tax ID # _____

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 on campus (ie, infusion, short stay, surgical suite) (22)
 Inpatient (21) observation possibility in lieu of inpatient admission? Ambulatory surgical center (24)
Yes No Other _____

TREATMENT OPTIONS

For patients transitioning from the Low Dose to the High Dose Regimen:

Administer one 50 mg bolus dose 4 months (+/- 14 days) after last 12 mg dose. Administer 28 mg maintenance dose once every 4 months thereafter.

- SPINRAZA (nusinersen) injection 50 mg/5 mL (10 mg/mL) in a single-dose vial
- SPINRAZA (nusinersen) injection 28 mg/5 mL (5.6 mg/mL) in a single-dose vial

- One 50 mg bolus dose
 One year of 28 mg maintenance doses (3 doses)
 One 50 mg bolus dose with one year of 28 mg maintenance doses (4 doses)

OR

For patients initiating the High Dose Regimen: Administer one 50 mg dose followed by a second 50 mg dose 14 days later. Administer 28 mg maintenance dose once every 4 months thereafter.

- SPINRAZA (nusinersen) injection 50 mg/5 mL (10 mg/mL) in a single-dose vial
 - SPINRAZA (nusinersen) injection 28 mg/5 mL (5.6 mg/mL) in a single-dose vial
- Two 50 mg loading doses
 One year of 28 mg maintenance doses (3 doses)
 Two 50 mg loading doses with one year of 28 mg maintenance doses (5 doses)

PRESCRIPTION FOR SPECIALTY PHARMACY (OPTIONAL)†

*Print name _____ *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.

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 _____

†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.