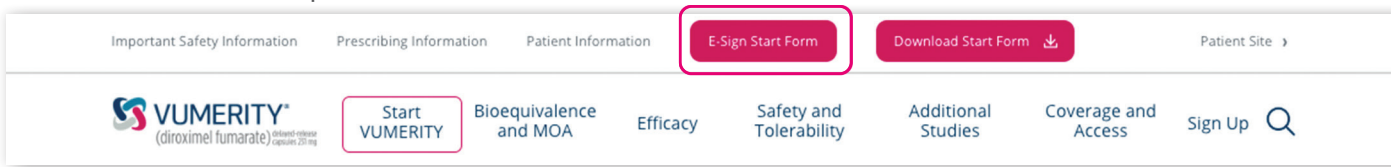


E-Sign Biogen[®] Start Forms via DocuSign



1

Visit www.vumerityhcp.com to initiate the process for completing a Biogen Start Form via DocuSign. Clicking on the **“E-Sign Start Form”** button will launch the DocuSign **“PowerForm.”** See VUMERITY example below.



2

Once the DocuSign **“PowerForm”** has loaded, you will enter in the names and email addresses for the 3 roles required to complete the process: Provider, Prescriber, and Patient.

After you have entered the names and email addresses, click the **“BEGIN SIGNING”** button to fill out the Prescriber and Patient Information on the Biogen Start Form.

Please note valid email addresses are needed for each of the following roles in order to initiate electronic completion of the Patient Start Form via DocuSign

- **Provider:** The HCP representative or office staff responsible for completing the Start Form information, including patient information
- **Prescriber:** The HCP responsible for signing the prescription on the Start Form
- **Patient:** The patient being prescribed therapy and responsible for completing and signing the patient sections on the Start Form

PowerForm Signer Information
Fill in the name and email for each signing role listed below. Signers will receive an email inviting them to sign this document. Please enter name and email to begin the signing process.

Provider
Name: *
Full Name
Email: *
Email Address

Please provide information for any other signers needed for this document.

Prescriber
Name: *
Full Name
Email: *
Email Address

Patient
Name: *
Full Name
Email: *
Email Address

BEGIN SIGNING

Enter Provider or HCP Representative name and email address

Enter Prescriber name and email address

Enter Patient name and email address

3

Fill in the Patient and Prescriber information on the Start Form and click the **“FINISH”** button at the top of the screen.

Enter date with format MM/DD/YYYY

FINISH FINISH LATER OTHER ACTIONS

START FORM

Enter Patient Information

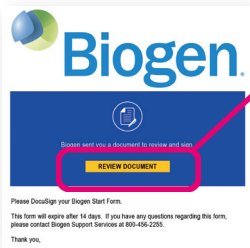
Click the paper clip to attach copies of the patient's insurance card

Enter Prescriber Information

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4

Once the HCP representative, **“Provider,”** completes the required fields, the Start Form is emailed to the **“Prescriber”** for review and signature.



This is an example of the email.

Please review the documents below. **FINISH** FINISH LATER OTHER ACTIONS ▾

START

Instructions for Healthcare Providers VUM-US-0010 v10 03/23

To prescribe VUMERITY, please follow these steps:

- After discussing VUMERITY with your patient, have your patient read the Patient Consent Information and, if interested, respond accordingly on the accompanying Start Form.

Biogen takes your patient's confidentiality very seriously. While patients are not required to sign the Start Form in order to receive VUMERITY, signing these lines will expedite their enrollment in Biogen Support Services, such as the Biogen Copay Program (call 1-800-456-2255 for eligibility guidelines). In addition, with these signatures Biogen will have access to your patient's prescription status should you or your patient need assistance.

Prescriber Authorization
 I authorize Biogen as my designee agent and on behalf of my patient to forward the above statement of medical necessity and furnish any information on this form to the issuer of the above-named insurance and to forward the above statement, to date by the issuer under applicable law to the pharmacy chosen by the above-named patient. I certify that the above information is accurate to the best of my knowledge, and I will be responsible for the patient's insurance coverage.

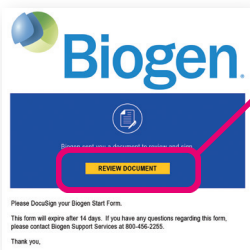
Prescriber signature (signature as written) _____ Date _____
 Signature stamp (not acceptable) _____ Date _____

* These should not start until the Board of Pharmacy and Industrial Affairs verify prescriber requirements. In New York, please attach copies of all prescriber or Other New York State Prescriber forms. * Transfer of ownership will require specific prescriber requirements and a prescriber sign-off specific to the program. See specific requirements and specific requirements outlined in a separate document.

©2023 Biogen. All rights reserved. **VUMERITY**
 (diroxime fumarate) delayed-release capsules 231 mg

5

Once the **“Prescriber”** completes the required fields, the Start Form is emailed to the **“Patient”** for review and signature.



This is an example of the email.

START FORM Phone: 1-800-456-2255 Fax: 1-855-474-3067 VUM-US-0010 v10 03/23

FILL IN

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 representative _____ Date _____
 If signed by patient representative, please explain authority to act on behalf of the patient:

II. 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):
 Care partner (first name) _____ Relationship _____
 Care partner email _____ Phone _____

III. Marketing Authorization
 I have read and understand the Marketing Authorization and agree to the terms.
 Signature of patient or patient representative _____ Date _____

IV. Government Payer Attestation
 Please check the applicable box to attest whether or not you have a government payer:
 I attest to all of the statements in Section IV on the previous page and confirm that I do not have a federally funded health insurance or will not use my federally funded health insurance to cover any portion of the costs of my Biogen medication while I am enrolled in certain Biogen programs.
 I attest that I do have a federally funded health insurance and intend to use it to cover the costs associated with my Biogen medication.

Patient Information
 Date of birth: 03/31/2023 Male Female
 First name: test MI: test Last name: test
 Address: test City: test State: 12345 Zip: test
 Other address: _____
 Home phone (patient): _____ Preferred number
 Cell phone (patient): _____ Preferred number
 OK to leave voicemail, text message, and/or email with care partner
 Best time to reach me: Morning Afternoon Evening

Pharmacy Benefit Information
 Attach copies of both sides of patient's pharmacy benefit cards.
 Check if no coverage Check if patient has secondary insurance