# Medical Information Request Form

Medical Information
https://medinfo.biogen.com
866-MED-INFO [866-633-4636]
medinfo@biogen.com

INSTRUCTIONS:
1. Complete **ALL** fields from sections A and B of the form (unless noted optional) legibly.
2. Include only one requestor per form.
3. Fax completed form to **877-462-1530** or email to **medinfo@biogen.com**

## A. Healthcare Professional Contact Information:

Requestor's Name:

Degree ☐MD ☐DO ☐PharmD ☐RPh ☐PA ☐NP ☐RN ☐Other: _____

Institution/Office:

Street Address:

| City: | State: | Zip Code: |
|---|---|---|
| Telephone Number (Including Area Code): | Fax Number (optional): | |

Email Address (optional):

## B. Unsolicited Medical Information Request:

Please check product(s) for information:

**Neurology**

☐ AVONEX® (interferon beta-1a) ☐ TYSABRI® (natalizumab) ☐ SPINRAZA® (nusinersen)
☐ PLEGRIDY® (peginterferon beta-1a) ☐ TECFIDERA® (dimethyl fumarate)

**Pipeline**

☐ Aducanumab (Aβ mAb)

☐ OTHER: _____

Inquiry:

Please check one:

_____This inquiry does not represent an adverse event experienced by a patient

_____This inquiry represents an adverse event experienced by a patient:

Patient Name or Initials _____DOB_____ Gender _____

Health Care Professional's Signature: _____ Date of Request:_____

Preferred method of response: ☐Fax ☐Mail ☐Email ☐Phone

## C. Representative Contact Information: (To Be Completed by Representative)

***By submitting this form, I certify that this request for information was initiated by the healthcare professional stated above, and was not solicited by me in any manner.***

| Representative Name: | Representative Type and Territory: | Primary Telephone Number: |
|---|---|---|