BETASERON Patient Setup & Enrollment Form

All information below is required. Completed forms may help speed service.

Fax completed form to BETAPLUS at 1-866-248-8575.

Questions? Call BETAPLUS at 1-800-788-1467.

BETASERON® (interferon beta-1b) 0.3 mg for SC injection

➤ STEP 1: BETAPLUS® ENROLLMENT

I have read the description of the BETAPLUS program and understand I am opting into BETAPLUS, including the below training selection.

☐ Provide training on BETASERON and/or autoinjector, including dispensing of autoinjector and training kit (placebo/syringe) as required

☐ No training or autoinjector required

STEP 2: PATIENT INFORMATION

Patient Name

Address

City State ZIP

Home Phone Cell Phone

Preferred Time to Call

Sex: ☐ Male ☐ Female Date of Birth

Patient Social Security #

Email

The following information should be filled out by your healthcare provider

STEP 3: INSURANCE INFORMATION

Primary Medical Insurance

☐ Uninsured/Self-pay

Policy Holder

ID # Group #

Phone

Primary Pharmacy Benefit Manager (Please provide a copy of card)

ID # Group #

Phone

BIN # PCN #

STEP 4: PHYSICIAN INFORMATION

Physician Name

(check one) ☐ MD ☐ DO ☐ PA ☐ NP

NPI # DEA #

Practice Name

Address

City State ZIP

Phone Fax

Contact Name

Contact Email/Phone

STEP 5: PRESCRIPTION

Prescribe BETASERON® (interferon beta-1b)

Rx: BETASERON® (interferon beta-1b)

Dispense BETASERON (check one)

☐ 1 box (14 vials) 0.25 mg/1 mL with 12 refills (may supply up to 3 months at a time)

☐ 1 box (14 vials) 0.25 mg/1 mL _____ refills

Select Dosing (check one)

☐ Sig: Weeks 1–2: 0.0625 mg SC qod Weeks 3–4: 0.125 mg SC qod

Weeks 5–6: 0.1875 mg SC qod Weeks 7+: 0.25 mg SC qod

☐ Maintenance dose 0.25 mg SC qod

☐ Other Sig:

BETA Bridge Enrollment Request*

☐ If eligible, dispense a temporary supply of BETASERON to patient facing a coverage gap

Rx: BETASERON® (interferon beta-1b)

Dispense BETASERON (check one)

☐ 1 box (14 vials) 0.25 mg/1 mL with 12 refills (may supply up to 3 months at a time)

☐ 1 box (14 vials) 0.25 mg/1 mL _____ refills

Select Dosing (check one)

☐ Sig: Weeks 1–2: 0.0625 mg SC qod Weeks 3–4: 0.125 mg SC qod

Weeks 5–6: 0.1875 mg SC qod Weeks 7+: 0.25 mg SC qod

☐ Maintenance dose 0.25 mg SC qod

☐ Other Sig:

☐ Newly Diagnosed (New BETASERON Patient) ☐ Previously Diagnosed (New BETASERON Patient) ☐ Restart (Previous BETASERON Patient) ☐ Current BETASERON Patient

STEP 6: PHYSICIAN AUTHORIZATION AND STATEMENT OF MEDICAL NECESSITY

Primary diagnosis: ICD-10 Code CM G35: I certify that the prescribed therapy is medically necessary for the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations. This statement is accurate to the best of my knowledge.

Patient was previously treated with (list all): _____

Reason for discontinuation: _____

I authorize Bayer and its Healthcare Partners to be my designated agent(s) and (1) to provide any information on this form to the insurer of the above-named patient and (2) to forward the above prescription, by fax or any other mode of delivery, to the pharmacy.

Prescriber Signature **Date**

Please see full Prescribing Information.

Patient Authorization Form for BETASERON® (interferon beta-1b) Patients

PATIENT HIPAA AUTHORIZATION

I voluntarily provide this Authorization for the use and disclosure of my Protected Health Information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). I understand that PHI is health information that identifies me or that could reasonably be used to identify me. I authorize my healthcare provider, including my physician and pharmacy, and my health plan, to disclose to Bayer and its contracted agents my name, address, telephone number, health insurance status and coverage, and such medical information as may be necessary for me to enroll in the BETAPLUS® program. I understand this disclosure(s) will contain PHI, including information about my current medical condition, treatment, coordination of treatment and receipt of medication. I allow the use and disclosure of my PHI to Bayer and its contracted agents for the following purposes:

- To verify my insurance information and coverage
- To ensure the accuracy and completeness of this form
- To help with my insurance coverage questions for Bayer medications
- To determine if I qualify for other Bayer patient support programs
- To determine my eligibility for other sources of prescription medication financial assistance
- To provide education, training, and ongoing support on the use of my Bayer medication
- To send me information on Bayer products and services related to my treatment
- To send me refill reminders for my Bayer prescription medication and to encourage its appropriate use
- To communicate with me, my healthcare providers and health plan about my medical care and treatment
- To contact me for market research feedback, sales support purposes, and as necessary to comply with applicable laws

I understand that:

- This Authorization will remain in effect until the end of my participation in the BETAPLUS program or 5 years from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to: BETAPLUS, 6251 Chancellor Drive, Suite 101, Orlando, FL 32809; or faxing my request to 1-866-248-8575.
- If I cancel this Authorization, my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, the revocation will not affect prior use or disclosure of my PHI in reliance on this Authorization.
- That entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law. It may become available in the public domain.
- I do not need to sign this Authorization to receive (i) medical treatment or medication or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this Authorization, I may not participate in the BETAPLUS program or be eligible for other Bayer patient support programs.
- I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosures of PHI. I understand that I am entitled to receive a signed copy of this Authorization and I can also get a copy by contacting BETAPLUS at 1-844-788-1470.

Signature of patient or authorized patient representative

Date

Printed name of authorized patient representative (if patient representative signs above)

Authorized patient representative's relationship to the patient (parent, guardian, etc.), if patient representative signs above

Separate along perforation. Patient: keep this page for your records. Doctor's office: please fax completed form on right to BETAPLUS at 1-866-248-8575. Questions? Call BETAPLUS at 1-800-788-1467.

Please see full Prescribing Information.

INDICATIONS

BETASERON® (interferon beta-1b) is a prescription medicine used to treat relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

IMPORTANT SAFETY INFORMATION

Do not take BETASERON if you are allergic to interferon beta-1b, to another interferon beta, to human albumin, or mannitol.

BETASERON can cause serious side effects, including:

Liver Problems Including Liver Failure. Symptoms of liver problems may include yellowing of your eyes, itchy skin, feeling very tired, flu-like symptoms, nausea or vomiting, bruising easily or bleeding problems. Your healthcare provider will do blood tests to check for these problems while you take BETASERON.

Serious Allergic Reactions. Serious allergic reactions can happen quickly and may happen after your first dose of BETASERON or after you have taken BETASERON many times. Symptoms may include difficulty breathing or swallowing, swelling of the mouth or tongue, rash, itching, or skin bumps.

Depression or Suicidal Thoughts. Call your healthcare provider right away if you have any of the following symptoms, especially if they are new, worse or worry you: thoughts about suicide or dying, new or worse depression (sinking feeling or sadness), new or worse anxiety (feeling uneasy, nervous or fearful for no reason), trouble sleeping (insomnia), acting aggressive, being angry, or violent, acting on dangerous impulses, hallucinations, other unusual changes in behavior or mood.

Other possible serious side effects with BETASERON include:

Heart Problems. BETASERON may worsen heart problems including congestive heart failure. Symptoms of heart problems may include swollen ankles, shortness of breath, decreased ability to exercise, fast heartbeat, tightness in chest, increased need to urinate at night, not being able to lay flat in bed.

Injection Site Problems. Serious skin reactions can happen in some people including areas of severe damage to skin and the tissue below the skin (necrosis). These reactions can happen anywhere you inject BETASERON. Symptoms of injection site problems may include swelling, redness, or pain at the injection site, fluid drainage from the injection site, and breaks in your skin or blue-black skin discoloration. Call your healthcare provider right away if an injection site becomes swollen and painful or the area looks infected. You may have a skin infection or an area of severe skin damage (necrosis) requiring treatment by a healthcare provider.

Flu-like Symptoms. BETASERON can cause flu-like symptoms including fever, chills, tiredness, sweating, muscle aches when you first start to use it. These symptoms may decrease over time. Taking medicines for fever and pain relief on the days you are using BETASERON may help decrease these symptoms.

Seizures. Some people have had seizures while taking BETASERON, including people who have never had seizures before. It is not known if the seizures were related to MS, to BETASERON, or to a combination of both. If you have a seizure after taking BETASERON call your healthcare provider right away.

Blood Problems. You may have a drop in the levels of infection-fighting white blood cells, red blood cells, or cells that help you form blood clots. If drops in levels are severe, they can lessen your ability to fight infections, make you feel tired or sluggish or cause you to bruise or bleed easily.

Pregnancy:

Tell your doctor if you are pregnant or plan to become pregnant.

Most Common Side Effects:

The most common side effects of BETASERON include low white blood cell count, increases in your liver enzymes, headache, increase in your muscle tension, pain, rash, problems sleeping, stomach pain, weakness. These are not all the possible side effects of BETASERON.

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. Tell your healthcare provider about all the medicines you take and your medical conditions.

Please see full Prescribing Information for additional information, and talk to your healthcare provider.

You are encouraged to report side effects or quality complaints of prescription drugs to the FDA.
Visit **www.fda.gov/medwatch** or call **1-800-FDA-1088**.

BETASERON® (interferon beta-1b)
0.3 mg for SC injection