Dear <Prescriber Name>,

Our records indicate that it has been 12 weeks since <Patient Name> received his or her first dose of TYSABRI. The Prescribing Information states that if a patient with Crohn’s disease has not experienced a therapeutic benefit by 12 weeks of induction of therapy she/he should be discontinued from TYSABRI treatment.

This questionnaire is necessary to fulfill the tracking requirements of the TOUCH Prescribing Program for Crohn’s disease patients treated with TYSABRI. You may also be contacted for additional information in response to answers provided on this form.

Submit the completed evaluation to Biogen Idec via TOUCH On-Line (www.touchprogram.com) OR fax (1-800-840-1278) and place one copy in the patient’s record.

Please answer Yes or No to the following questions:

1. Has this patient experienced a therapeutic benefit within 12 weeks after starting TYSABRI treatment?
   - Yes
   - No*
   *TYSABRI should be discontinued if the patient has not experienced a therapeutic benefit by 12 weeks of induction therapy with TYSABRI.

2. Will the patient continue on TYSABRI?
   - Yes
   - No*
   *If you answer No, Biogen Idec will contact the patient and the infusion STOP TYSABRI TREATMENT. The patient will not be eligible to receive TYSABRI treatment, and you will receive a discontinuation questionnaire to complete for this patient.

If you have questions, or if you need additional information, please call 1-800-456-2255 from 8:30 AM to 8:00 PM (ET).

Prescriber signature: __________________________ Date (MM/DD/YYYY): _____/_____/

(If applicable) Print TOUCH Authorized Prescriber Delegate Name: __________________________

Please Note: A TOUCH authorized physician may complete this form on behalf of the TOUCH Prescriber of record. This questionnaire will be used consistent with the TOUCH Prescriber/Patient Enrollment form signed by you and your patient with HIPAA and applicable privacy rules.

For full Prescribing Information, including Boxed Warning, please see www.TYSABRI.com.