Provider and Treatment Site Enrollment Form

Enroll in the PATH program

The PATH program provides financial assistance for ADUHELM® (aducanumab-avwa) to eligible patients, which may help patients access their medication.*

If you are a provider or treatment site, please fill out this form to enroll in the PATH program.

Please see full Prescribing Information, including Boxed Warning and Medication Guide.

INSTRUCTIONS

This form provides information to **Biogen Support Services for Patients** to enroll you as an approved healthcare provider for the PATH program. Please complete the electronic version of this form and return digitally. If you prefer, you may also complete and return via fax to our toll-free fax number: **1-888-381-0696**.

1. Before you complete this form, please be sure you have completed the required ADUHELM educational module. If you need access to this module, please reach out to your Biogen Account Manager.
2. Complete the enrollment form. Note that if the treatment site is a separate facility from your site of care, the treatment site's information will need to be provided and the site will need to enroll in the PATH program separately and complete the ADUHELM educational module.
3. Submit the completed form via DocuSign or fax the completed form to **1-888-381-0696**. Your patient(s) have a separate form that has a clinical attestation portion that you will also need to fill out.

*Patient out-of-pocket cost may vary based on financial and other income considerations. This program only covers the cost of ADUHELM. Other services or fees associated with treatment are not included and patient may have out-of-pocket costs associated with the same. Other restrictions apply. Biogen reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. New enrollment ends 9/1/2024; program ends 12/31/2024. Contact Biogen Support Services for Patients for full program details and Terms and Conditions.

Questions?
Contact Biogen Support Services for Patients at 1-833-425-9360

Indicates required information

PATH Patient Access to Therapy

THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE PRESCRIBER

★ Prescriber Information

First Name | Last Name

Practice/Institution Name

Address

City | State | ZIP Code

Office Contact

Direct Number | Email

Phone | Fax | Prescriber NPI

PTAN (if issued)

★ Signature of Healthcare Provider | Date (MM/DD/YYYY)

☐ Prescriber will administer ADUHELM® (aducanumab-avwa)

OR

☐ Prescriber will refer ADUHELM treatment to another site (please fill out information on page 3)

★ ADUHELM Educational Module Attestation

☐ I attest that I have completed the ADUHELM educational module.

If you have not received the ADUHELM educational module, please reach out to your Biogen Account Manager.

★ Billing Attestation

☐ I will not charge the patient more than their out-of-pocket cost for ADUHELM. I understand that by participating in this program, I cannot bill the patient's insurance for the cost of ADUHELM.

★ Prescriber Signature (Stamps Not Acceptable) | Date (MM/DD/YYYY)

Authorization for Biogen to Provide Information to Patients Seeking Enrolled Healthcare Provider or Treatment Site (optional)

☐ I am willing to have Biogen Support Services for Patients provide my information to patients that do not have an enrolled provider or treatment site.

In doing so, I authorize Biogen to share the above-listed information, including a subset of this information and information subsequently provided for this purpose. I attest that I have the authority to provide this information on behalf of the site of care listed above and that all the information I have is true and accurate as of the date of submission. If there is any information I would like changed or removed, I must contact Biogen Support Services for Patients to request changes.

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**.

Please complete the electronic version of this form and return digitally. If you prefer, you may also complete and return via fax to our toll-free fax number: 1-888-381-0696.

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Questions?
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Indicates required information

PATH Patient Access to Therapy

THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE TREATMENT SITE ADMINISTRATOR

★ Treatment Site Information

First Name | Last Name

Practice/Institution Name

Address

City | State | ZIP Code

Office Contact

Direct Number | Email

Phone | Fax | Prescriber NPI

★ Treatment Site Administrator | Date (MM/DD/YYYY)

Billing Address for payment from PATH Program (if different from HCP/Site of Care Information or Treatment Site Information above)

Corporate/Billing Site Name | **Name of Contact Person** (First & Last Name)

Street Address or Site Authorization Number

City | State | ZIP Code

Office Contact

Phone | Email

NPI (optional) | TIN

★ ADUHELM Educational Module Attestation

☐ I attest that I have completed the ADUHELM educational module.

If you have not received the ADUHELM educational module, please reach out to your Biogen Account Manager.

★ Billing Attestation

☐ I will not charge the patient more than their out-of-pocket cost for ADUHELM. I understand that by participating in this program, I cannot bill the patient's insurance for the cost of ADUHELM.

★ Signature of Treatment Site Administrator (Stamps Not Acceptable) | Date (MM/DD/YYYY)

Authorization for Biogen to Provide Information to Patients Seeking Enrolled Healthcare Provider or Treatment Site (optional)

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