52 weeks to stay on track
Keeping a treatment journal can help you maintain your Rebif® (interferon beta-1a) routine and is a great collaborative tool to refer to at your doctor visits. The following pages give you an organized place to record:

- The day and time of each injection
- The site of each injection
- Injection-site reactions or side effects

When you reach the end of this treatment journal, you can order a replacement from MS LifeLines® by calling 1-877-447-3243.

In addition to your weekly treatment journal, this book also includes helpful tips for managing common side effects on pages 106–108 and a section with a handy doctor visit checklist beginning on page 109.
Visiting your doctor? Organization is key.

Sometimes, it can be hard to remember everything you’d like to discuss with your doctor, and this doctor visit checklist can help you get organized. Here, you’ll find space to describe your symptoms and a place to write down your questions and take notes during your visit.

<table>
<thead>
<tr>
<th>Questions or comments to discuss with your doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>What new medications, if any, have you started since your last visit?</td>
</tr>
<tr>
<td>Any new health care providers?</td>
</tr>
<tr>
<td>What’s going well?</td>
</tr>
<tr>
<td>What’s changed?</td>
</tr>
<tr>
<td>Top 3 things to discuss with your doctor</td>
</tr>
</tbody>
</table>

### Doctor Visit Checklist

You may want to use this checklist to get organized for doctor’s visits and bring it with you to your appointment. If you have questions, call an MS Lifelines Nurse, toll-free, at 1-877-447-3243, Monday through Friday, 8 am to 10 pm ET and Saturday and Sunday, 9 am to 5 pm ET, or visit mslifelines.com.

<table>
<thead>
<tr>
<th>MS symptom</th>
<th>Is it old or new?</th>
<th>Is it worse?</th>
<th>Description and how long it lasted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues with memory, attention, or problem solving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression or mood swings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle stiffness or spasms (spasticity)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Weakness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Abnormal feelings and sensations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking and balance problems</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bowel or bladder problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat sensitivity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
__________________________
__________________________

**Injection site**

Front  Back

---

**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
__________________________
__________________________

**Injection site**

Front  Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

**Date:** ______  **Time of injection:** ______

**Injection-site reaction?**  Yes  |  No

If yes, describe: ________________

________________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.
In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

*Day: S M T W T F S*

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
______________________________

**Injection site**

[Diagram showing injection sites on front and back of the body]

---

**Injection 2**

*Day: S M T W T F S*

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
______________________________

**Injection site**

[Diagram showing injection sites on front and back of the body]
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ______________________

_______________________________

_______________________________

**Injection site**

Front

Back

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Week 3

Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:** S M T W T F S

**Date:** ______  **Time of injection:** ______

**Injection-site reaction?**  Yes  |  No

If yes, describe: ______________________

_____________________________

_____________________________

**Injection site**

**Front**  **Back**

---

**Injection 2**

**Day:** S M T W T F S

**Date:** ______  **Time of injection:** ______

**Injection-site reaction?**  Yes  |  No

If yes, describe: ______________________

_____________________________

_____________________________

**Injection site**

**Front**  **Back**
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day: S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________

__________________________

Injection site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: __________________________
____________________________
____________________________

**Injection site**

Front | Back

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: __________________________
____________________________
____________________________

**Injection site**

Front | Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:**  S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________
______________________________

**Injection site**

---

Notes

______________________________
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______________________________

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**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

_______________________________

**Injection site**

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

_______________________________

**Injection site**
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________
________________________________________________________________________
________________________________________________________________________

Injection site

Notes

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

Front  Back

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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**Injection 1**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________
_________________________________________
_________________________________________

**Injection site**

**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________
_________________________________________
_________________________________________

**Injection site**
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ______________________
______________________________
______________________________

**Injection site**

---

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Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day: S  M  T  W  T  F  S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: _______________________

_______________________________

Injection site

**Injection 2**

**Day: S  M  T  W  T  F  S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: _______________________

_______________________________

Injection site
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: __________________________

________________________________________

Injection site

Notes

________________________________________

________________________________________

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________________________________________

________________________________________

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.
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### Injection 1

**Day:** S M T W T F S

**Date:** _______ **Time of injection:** _______

Injection-site reaction?  Yes | No
If yes, describe: ____________________________
______________________________
______________________________

**Injection site**

![Injection site diagram](image)

- Front
- Back

### Injection 2

**Day:** S M T W T F S

**Date:** _______ **Time of injection:** _______

Injection-site reaction?  Yes | No
If yes, describe: ____________________________
______________________________
______________________________

**Injection site**

![Injection site diagram](image)

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________

________________________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.
In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: ____________________________
___________________________________________________________________________
___________________________________________________________________________

**Injection site**

[Diagram of injection sites on the front and back of the body]

**Injection 2**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: ____________________________
___________________________________________________________________________
___________________________________________________________________________

**Injection site**

[Diagram of injection sites on the front and back of the body]
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

**Injection 3**

**Day:** S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________

________________________________________

**Injection site**

Please see **Rebif® (interferon beta-1a)** Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

- **Day:** S M T W T F S
- **Date:** __________ **Time of injection:** ______
- **Injection-site reaction?** Yes | No
- If yes, describe: ____________________________
  ____________________________
  ____________________________

**Injection site**

- Front
- Back

**Injection 2**

- **Day:** S M T W T F S
- **Date:** __________ **Time of injection:** ______
- **Injection-site reaction?** Yes | No
- If yes, describe: ____________________________
  ____________________________
  ____________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: __________________________

______________________________

______________________________

**Notes**

_____________________________________

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_____________________________________

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**Injection 1**

**Injection site**

Day:  S  M  T  W  T  F  S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
______________________________
______________________________

**Injection 2**

**Injection site**

Day:  S  M  T  W  T  F  S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
______________________________
______________________________
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: __________________________

__________________________

Injection site

Notes

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__________________________

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**Injection 1**

- **Day: S M T W T F S**
- **Date:** ______  **Time of injection:** ______
- **Injection-site reaction?**  Yes | No
- **If yes, describe:** ________________  
  ________________  
  ________________  

**Injection site**

- Front  
- Back

---

**Injection 2**

- **Day: S M T W T F S**
- **Date:** ______  **Time of injection:** ______
- **Injection-site reaction?**  Yes | No
- **If yes, describe:** ________________  
  ________________  
  ________________  

**Injection site**

- Front  
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

### Injection 3

<table>
<thead>
<tr>
<th>Day:</th>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
</table>

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ______________________

______________________________

______________________________

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**Injection site**

- Front
- Back

---

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**Injection 1**

**Day:** S M T W T F S

**Date:** ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: _______________________

______________________________

**Injection site**

![Injection site diagram](Front Back)

**Injection 2**

**Day:** S M T W T F S

**Date:** ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: _______________________

______________________________

**Injection site**

![Injection site diagram](Front Back)
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: _____ Time of injection: _____

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

Notes

___________________________________________________________________________

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**Injection 1**

**Day: S M T W T F S**

Date: ________ Time of injection: ________

Injection-site reaction? Yes | No

If yes, describe: __________________________
______________________________
______________________________

**Injection site**

---

**Injection 2**

**Day: S M T W T F S**

Date: ________ Time of injection: ________

Injection-site reaction? Yes | No

If yes, describe: __________________________
______________________________
______________________________

**Injection site**

---
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**Injection 3**

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ___________________________

__________________________________________________________________________

**Notes**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Injection site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: ________________

______________

______________

**Injection site**

Front Back

**Injection 2**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: ________________

______________

______________

**Injection site**

Front Back
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

**Injection 3**

**Day: S  M  T  W  T  F  S**

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________
______________________________
______________________________

**Notes**

______________________________
______________________________
______________________________

Please see **Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.**
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: __________________________
______________________________
______________________________

**Injection site**

Front  Back

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: __________________________
______________________________
______________________________

**Injection site**

Front  Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

### Injection 3

**Day: S M T W T F S**

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: __________________________

______________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

### Injection 1

**Day: S M T W T F S**

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________

______________________________

______________________________

**Injection site**

Front  Back

### Injection 2

**Day: S M T W T F S**

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________

______________________________

______________________________

**Injection site**

Front  Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

### Injection 3

<table>
<thead>
<tr>
<th>Day:</th>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
</table>

Date: _____ Time of injection: _____

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________

______________________________

Notes

______________________________

______________________________

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______________________________

______________________________

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**Injection 1**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

______________________________

______________________________

**Injection 2**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

______________________________

______________________________
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Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ____________________________

______________________________

______________________________

______________________________

______________________________

Infection site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

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**Injection 1**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________


**Injection 2**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________


Injection site
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________
_______________________________
_______________________________

Injection site

Notes

_______________________________
_______________________________
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**Injection 1**

**Day: S  M  T  W  T  F  S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________

_______________________________

**Injection 2**

**Day: S  M  T  W  T  F  S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________

_______________________________

**Injection site**
Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No
If yes, describe: _________________________
                         _________________________
                         _________________________

Injection site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.

If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

Injection 1

Day: S M T W T F S
Date: _______ Time of injection: _______
Injection-site reaction? Yes | No
If yes, describe: ______________________
______________________________
______________________________

Injection site

Front Back

Injection 2

Day: S M T W T F S
Date: _______ Time of injection: _______
Injection-site reaction? Yes | No
If yes, describe: ______________________
______________________________
______________________________

Injection site

Front Back
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

**Injection 3**

**Day:**  S  M  T  W  T  F  S

Date: ____ Time of injection: ____

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________

______________________________

**Injection site**

![Injection site diagram]

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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**Injection 1**

**Day: S M T W T F S**

Date: ______ Time of injection: ______

Injection-site reaction?   Yes | No
If yes, describe: ___________________________
______________________________
______________________________

**Injection site**

**Injection 2**

**Day: S M T W T F S**

Date: ______ Time of injection: ______

Injection-site reaction?   Yes | No
If yes, describe: ___________________________
______________________________
______________________________

**Injection site**
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: _____ Time of injection: _____

Injection-site reaction? Yes | No

If yes, describe: ______________________

______________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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**Injection 1**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

______________________________

______________________________

**Injection site**

**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

______________________________

______________________________

**Injection site**
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

### Injection 3

**Day:** S M T W T F S  

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: _______________

______________

______________

**Injection site**

![Injection site diagram]

Please see **Rebif® (interferon beta-1a)** Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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### Injection 1

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction?   Yes | No

If yes, describe: __________________________
______________________________
______________________________

### Injection 2

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction?   Yes | No

If yes, describe: __________________________
______________________________
______________________________

---

**Injection site**

- **Front**
- **Back**
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ______________________________

______________________________

**Injection site**

Please see **Rebif® (interferon beta-1a)** Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:** S M T W T F S

**Date:** _______ **Time of injection:** _______

Injection-site reaction? **Yes** | **No**

If yes, describe: __________________________

________________________________________

**Injection site**

**Injection 2**

**Day:** S M T W T F S

**Date:** _______ **Time of injection:** _______

Injection-site reaction? **Yes** | **No**

If yes, describe: __________________________

________________________________________

**Injection site**
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

### Injection 3

<table>
<thead>
<tr>
<th>Day: S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
</table>

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ________________

_____________________________________________________________________

**Injection site**

![Injection sites diagram]

Notes

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Please see **Rebif® (interferon beta-1a)** Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________
________________________________________________________________________
________________________________________________________________________

**Injection site**

- Front
- Back

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________
________________________________________________________________________
________________________________________________________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________

______________________________

______________________________

______________________________

______________________________

______________________________

Injection site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
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<tr>
<td>If yes, describe:</td>
<td></td>
<td></td>
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</tbody>
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**Injection 2**

<table>
<thead>
<tr>
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<th>Date: ______</th>
<th>Time of injection: ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection-site reaction?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Injection site

---

Week 27
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

**Injection 3**

<table>
<thead>
<tr>
<th>Day:</th>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
</table>

Date: _____ Time of injection: _____

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

______________________________

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Injection site</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Injection site diagram" /></td>
</tr>
</tbody>
</table>

Please see **Rebif® (interferon beta-1a) Prescribing Information and Medication Guide** enclosed and **Important Safety Information** on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:**

| S | M | T | W | T | F | S |

**Date:** _____  **Time of injection:** _____

**Injection-site reaction?**  Yes  |  No

If yes, describe: ______________________

_______________________________

_______________________________

**Injection site**

Front  |  Back

**Injection 2**

**Day:**

| S | M | T | W | T | F | S |

**Date:** _____  **Time of injection:** _____

**Injection-site reaction?**  Yes  |  No

If yes, describe: ______________________

_______________________________

_______________________________

**Injection site**

Front  |  Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: _______________

__________

Notes

______________________________

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Infection site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________
______________________________
______________________________

**Injection site**

- Front
- Back

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________
______________________________
______________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:**  
S M T W T F S

**Date:** ______  **Time of injection:** ______

**Injection-site reaction?**  
Yes | No

If yes, describe: ______________________

______________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Injection 2**

<table>
<thead>
<tr>
<th>Day:</th>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction?   Yes  |  No

If yes, describe: ______________

______________________________

______________________________

**Injection site**

**Injection site**

Front  

Back  

Front  

Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________

______________________________

______________________________

______________________________

Notes

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

Injections site

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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**Injection 1**

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: __________________________
________________________________________________________________________
________________________________________________________________________

**Injection 2**

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: __________________________
________________________________________________________________________
________________________________________________________________________

**Injection site**

Front Back

Front Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: _________________

__________________________

__________________________

Infection site

Notes

__________________________

__________________________

__________________________

__________________________

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**Injection 1**

Day: S M T W T F S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ______________________

_______________________________

_______________________________

**Injection site**

Front  Back

---

**Injection 2**

Day: S M T W T F S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ______________________

_______________________________

_______________________________

**Injection site**

Front  Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

Day:  S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________

______________________________

______________________________

**Notes**

______________________________

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______________________________

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### Injection 1

<table>
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<th>Day: S M T W T F S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: _______ Time of injection: _______</td>
</tr>
<tr>
<td>Injection-site reaction?</td>
</tr>
<tr>
<td>If yes, describe: ___________________________</td>
</tr>
<tr>
<td>___________________________</td>
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<tr>
<td>___________________________</td>
</tr>
</tbody>
</table>

**Injection site**

[Diagram of injection sites]

### Injection 2

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: _______ Time of injection: _______</td>
</tr>
<tr>
<td>Injection-site reaction?</td>
</tr>
<tr>
<td>If yes, describe: ___________________________</td>
</tr>
<tr>
<td>___________________________</td>
</tr>
<tr>
<td>___________________________</td>
</tr>
</tbody>
</table>

**Injection site**

[Diagram of injection sites]
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

______________________________

**Injection site**

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Record information about each of your 3 injections.
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**Injection 1**

**Day: S M T W T F S**

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: ______________
________________________________
________________________________

**Injection site**


**Injection 2**

**Day: S M T W T F S**

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: ______________
________________________________
________________________________

**Injection site**


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Injection 3

Day: S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: __________________________  
______________________________  
________________________________________

Injection site

Front  Back

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**Injection 1**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

______________________________

Injection site

---

**Injection 2**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

______________________________

Injection site
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________

_________________________________________________________________

**Injection site**

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Injection 1

Day: S M T W T F S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ____________________________

Injection site

Front Back

Injection 2

Day: S M T W T F S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ____________________________

Injection site

Front Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:**  S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________

__________________________________

**Injection site**

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Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

### Injection 1

**Day:** S M T W T F S

**Date:** _______  
**Time of injection:** _______

**Injection-site reaction?**  Yes  |  No

If yes, describe: __________________________
_________________________________________________________________________
_________________________________________________________________________

**Injection site**

- Front
- Back

### Injection 2

**Day:** S M T W T F S

**Date:** _______  
**Time of injection:** _______

**Injection-site reaction?**  Yes  |  No

If yes, describe: __________________________
_________________________________________________________________________
_________________________________________________________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day:  S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

__________________________

__________________________

__________________________

Injection site

Notes

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

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**Injection 1**

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______
Injection-site reaction?  Yes | No
If yes, describe: ________________
______________________________
______________________________

**Injection site**

![Injection site front and back](image)

**Injection 2**

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______
Injection-site reaction?  Yes | No
If yes, describe: ________________
______________________________
______________________________

**Injection site**

![Injection site front and back](image)
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: ____________________________

__________________________________________

**Injection site**

Front

Back

Notes

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.
In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Injection site**

Day: S  M  T  W  T  F  S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________

__________________________________________

**Injection 2**

**Injection site**

Day: S  M  T  W  T  F  S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________

__________________________________________

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If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S  M  T  W  T  F  S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________

______________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?   Yes  |  No

If yes, describe: _________________

_________________________________

**Injection site**

<table>
<thead>
<tr>
<th>Front</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Injection site Front" /></td>
<td><img src="image2" alt="Injection site Back" /></td>
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</tbody>
</table>

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?   Yes  |  No

If yes, describe: _________________

_________________________________

**Injection site**

<table>
<thead>
<tr>
<th>Front</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image3" alt="Injection site Front" /></td>
<td><img src="image4" alt="Injection site Back" /></td>
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</tbody>
</table>
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ____________________

______________________________

______________________________

**Injection site**

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.
In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________
_______________________________________________________________________
_______________________________________________________________________

**Injection site**

- Front
- Back

**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________
_______________________________________________________________________
_______________________________________________________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: _________________

______________________________________________________________________

**Injection site**

Please see **Rebif® (interferon beta-1a) Prescribing Information and Medication Guide** enclosed and **Important Safety Information** on pages 119–121.
Record information about each of your 3 injections.

In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

<table>
<thead>
<tr>
<th>Day:  S  M  T  W  T  F  S</th>
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</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No
If yes, describe: __________________________
______________________________
______________________________

**Injection site**

<table>
<thead>
<tr>
<th>Front</th>
<th>Back</th>
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</tbody>
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**Injection 2**

<table>
<thead>
<tr>
<th>Day:  S  M  T  W  T  F  S</th>
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</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No
If yes, describe: __________________________
______________________________
______________________________

**Injection site**

<table>
<thead>
<tr>
<th>Front</th>
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Week 42

84
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S  M  T  W  T  F  S

Date: ______ Time of injection: ______

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If yes, describe: ________________

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_______________________________

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**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: __________________________

______________________________

______________________________

Injection site

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**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: __________________________

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Injection site
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Day:  S  M  T  W  T  F  S

Date: ______  Time of injection: ______

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If yes, describe: ____________________

______________________________

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Injection site

Notes

______________________________

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Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: _________________

______________________________

______________________________

**Injection 2**

Day: S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: _________________

______________________________

______________________________

**Injection site**

Front | Back

Front | Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

<table>
<thead>
<tr>
<th>Injection 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day:</strong> S M T W T F S</td>
</tr>
</tbody>
</table>

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| Injection site |
|                |

Front  Back

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<tr>
<td>If yes, describe: ____________________________</td>
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<td>____________________________</td>
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**Injection 2**

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<tr>
<td>Injection-site reaction? Yes</td>
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<tr>
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Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No
If yes, describe: __________________________

Injection site

Notes

________________________________________

________________________________________

________________________________________

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________________________________________

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**Injection 1**

**Day: S  M  T  W  T  F  S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________
______________________________
______________________________

**Injection site**

**Injection 2**

**Day: S  M  T  W  T  F  S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes  |  No

If yes, describe: ______________________
______________________________
______________________________
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

- **Day:** S M T W T F S

- **Date:** _____  **Time of injection:** _____

- **Injection-site reaction?**  Yes  |  No

  If yes, describe: ________________  
  ________________  
  ________________

**Injection site**

![Injection site diagram]

**Notes**

- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________

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**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: _________________

______________________________

______________________________

Injection site

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction?  Yes | No

If yes, describe: _________________

______________________________

______________________________

Injection site
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:**  S  M  T  W  T  F  S  

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ________________________  

________________________________________________________________________

**Injection site**

Front  

Back

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

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**Injection 1**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ______________________
______________________________
______________________________

**Injection site**

- Front
- Back

**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ______________________
______________________________
______________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact **MS LifeLines® at 1-877-447-3243**, toll-free, 24/7.

---

**Injection 3**

**Day:** S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ____________________

__________________________

**Injection site**

Please see **Rebif® (interferon beta-1a)** Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections.

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### Injection 1

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________

___________________________

___________________________

**Injection site**

![Diagram of injection sites on front and back of body](image)

### Injection 2

<table>
<thead>
<tr>
<th>Day: S M T W T F S</th>
</tr>
</thead>
</table>

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ____________________

___________________________

___________________________

**Injection site**

![Diagram of injection sites on front and back of body](image)
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe:

Notes

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: __________________________

________________________________________

________________________________________

**Injection site**

**Front**

**Back**

---

**Injection 2**

**Day: S M T W T F S**

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: __________________________

________________________________________

________________________________________

**Injection site**

**Front**

**Back**
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction? Yes | No

If yes, describe: __________________________

________________________

---

**Notes**

________________________________________________________________________

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________________________________________________________________________

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
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<table>
<thead>
<tr>
<th>Injection 1</th>
<th>Injection 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day: S M T W T F S</strong></td>
<td><strong>Day: S M T W T F S</strong></td>
</tr>
<tr>
<td>Date: ______ Time of injection: ______</td>
<td>Date: ______ Time of injection: ______</td>
</tr>
<tr>
<td>Injection-site reaction? Yes</td>
<td>Injection-site reaction? Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>If yes, describe: ___________</td>
<td>If yes, describe: ___________</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Injection site**

- Front
- Back

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

Injection 3

Day: S M T W T F S

Date: ______ Time of injection: ______

Injection-site reaction?  Yes | No

If yes, describe: ________________

______________________________

______________________________

Injection site

Front  Back

Notes

________________________________________________________

________________________________________________________

________________________________________________________

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Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Record information about each of your 3 injections. In the notes section, list any side effects and/or MS symptoms you experience and anything you would like to discuss with your healthcare provider.

**Injection 1**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ______________________
_____________________________
_____________________________

**Injection site**

- Front
- Back

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**Injection 2**

**Day:** S M T W T F S

Date: _______ Time of injection: _______

Injection-site reaction? Yes | No

If yes, describe: ______________________
_____________________________
_____________________________

**Injection site**

- Front
- Back
If you have questions about your therapy, you can contact MS LifeLines® at 1-877-447-3243, toll-free, 24/7.

**Injection 3**

**Day:** S  M  T  W  T  F  S

Date: ______  Time of injection: ______

Injection-site reaction?  Yes  |  No

If yes, describe: ____________________________
__________________________________________________________________________
__________________________________________________________________________

**Injection site**

Front  Back

---

Please see Rebif® (interferon beta-1a) Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Injection-site reactions

One of the most common side effects of Rebif® (interferon beta-1a), injection-site reactions, refers to any redness, pain, irritation, swelling, color changes, or drainage of fluid that may occur at the site of your injection. Proper injection technique may help you manage some of these reactions.

You can receive tips for proper injection technique that may help with injection-site reactions from an MS LifeLines Nurse. MS LifeLines Nurse Support Specialists are available Monday through Friday, 8 AM to 10 PM ET and Saturday and Sunday, 9 AM to 5 PM ET. Call MS LifeLines®, toll-free, at 1-877-447-3243.

Tips that may help manage injection-site reactions

• Before injecting, you should allow Rebif to reach room temperature. It is recommended that you remove Rebif from the refrigerator at least 30 minutes prior to use. Never heat or microwave Rebif

• Use proper injection technique as instructed by your healthcare provider. Please see the Rebif Medication Guide enclosed
• Thoroughly clean the injection site with an alcohol swab or cotton ball with rubbing alcohol prior to injection. To avoid stinging, you should let your skin dry before you inject Rebif® (interferon beta-1a)

• To minimize discomfort, apply an ice pack or cold compress for no more than 2 minutes to the area before and after the injection

• Rotate the injection site, and inject only into healthy tissue. Wait at least 7 days before using the same spot again

• Do not inject Rebif into an area of your body where the skin is irritated, reddened, bruised, infected, or abnormal in any way

• Monitor your injection site for redness, swelling, or tenderness

---

**Important Safety Information**

Rebif may cause redness, pain, swelling, color changes (blue or black), and drainage of fluid at the place where an injection was given. Some patients have developed skin infections or areas of severe skin damage (necrosis) requiring treatment by a doctor. If one of your injection sites becomes swollen and painful or the area looks infected and it doesn’t heal within a few days, you should call your doctor. For more information, please see Medication Guide.

Please see Rebif Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
Flu-like symptoms

One of the most common side effects of Rebif® (interferon beta-1a) is flu-like symptoms, which can range from fever, chills, and sweating to muscle aches and tiredness.

It’s helpful to note that flu-like symptoms are not caused by a viral infection and do not include vomiting or diarrhea. For many people taking Rebif, flu-like symptoms may lessen or go away over time.

The following tips* may help you manage flu-like symptoms:

• **Stay hydrated.** Drinking plenty of water throughout the day is important and can help you stay cool.

• **Consider taking an over-the-counter pain reliever or fever reducer.** These are medicines you can buy at your local pharmacy without a prescription. These may also have their own side effects, so read the instructions carefully. Talk to your healthcare provider or an MS LifeLines Nurse about using over-the-counter pain relievers or fever reducers before or after injecting.

• **Find a time of day that works for you.** Some people inject Rebif around bedtime to help them sleep through some flu-like symptoms they may have. Others find that injecting earlier in the day works best for them. Remember to keep injections at least 48 hours apart.

• **Talk to your healthcare provider** about these and other ways to help manage your flu-like symptoms.

*These tips have been recommended by some healthcare providers.

Please see Rebif Prescribing Information and Medication Guide enclosed and Important Safety Information on pages 119–121.
You may want to use this checklist to get organized for doctor visits and bring it with you to your appointments. If you have questions, call an MS LifeLines Nurse, toll-free, at **1-877-447-3243**, Monday through Friday, 8 AM to 10 PM ET and Saturday and Sunday, 9 AM to 5 PM ET, or visit [mslifelines.com](http://mslifelines.com).

**Date: ________________**

<table>
<thead>
<tr>
<th>MS symptom</th>
<th>Is it old or new?</th>
<th>Is it worse?</th>
<th>Description and how long it lasted</th>
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</thead>
<tbody>
<tr>
<td>Issues with memory, attention, or problem solving</td>
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<tr>
<td>Depression or mood swings</td>
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<td></td>
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<tr>
<td>Vision problems</td>
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<tr>
<td>Muscle stiffness or spasms (spasticity)</td>
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<tr>
<td>Weakness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fatigue</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Abnormal feelings and sensations</td>
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<td></td>
<td></td>
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<tr>
<td>Walking and balance problems</td>
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<tr>
<td>Bowel or bladder problems</td>
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<tr>
<td>Sexual issues</td>
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<tr>
<td>Heat sensitivity</td>
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</tbody>
</table>
Questions or comments to discuss with your doctor

What new medications, if any, have you started since your last visit?

Any new healthcare providers?

What’s going well?

What’s changed?

Top 3 things to discuss with your doctor
# Doctor Visit Checklist

You may want to use this checklist to get organized for doctor visits and bring it with you to your appointments. If you have questions, call an MS LifeLines Nurse, toll-free, at **1-877-447-3243**, Monday through Friday, 8 AM to 10 PM ET and Saturday and Sunday, 9 AM to 5 PM ET, or visit [mslifelines.com](http://mslifelines.com).

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**Date: __________________**
Questions or comments to discuss with your doctor

What new medications, if any, have you started since your last visit?

Any new healthcare providers?

What's going well?

What's changed?

Top 3 things to discuss with your doctor
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Any new healthcare providers?

What’s going well?

What’s changed?

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Doctor Visit Checklist

You may want to use this checklist to get organized for doctor visits and bring it with you to your appointments. If you have questions, call an MS LifeLines Nurse, toll-free, at **1-877-447-3243**, Monday through Friday, 8 AM to 10 PM ET and Saturday and Sunday, 9 AM to 5 PM ET, or visit [mslifelines.com](http://mslifelines.com).

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Indication

Rebif® (interferon beta-1a) is used to treat relapsing forms of MS to decrease the frequency of relapses and delay the occurrence of some of the physical disability that is common in people with MS.

Important Safety Information

Before beginning treatment, you should discuss the potential benefits and risks associated with Rebif with your healthcare provider.

Rebif can cause serious side effects. Tell your healthcare provider right away if you have any of the symptoms listed below while taking Rebif.

• Behavioral health problems, including depression and suicidal thoughts. You may have mood problems including depression (feeling hopeless or feeling bad about yourself), and thoughts of hurting yourself or suicide

• Liver problems or worsening of liver problems, including liver failure. Symptoms may include nausea, loss of appetite, tiredness, dark colored urine and pale stools, yellowing of your skin or the white part of your eye, bleeding more easily than normal, confusion, and sleepiness. During your treatment with Rebif you will need to see your healthcare provider regularly and have regular blood tests to check for side effects

• Serious allergic and skin reactions. Symptoms may include itching, swelling of your face, eyes, lips, tongue or throat, trouble breathing, anxiousness, feeling faint, skin rash, hives, sores in your mouth, or skin blisters and peels

• Injection site problems. Symptoms at the injection site may include redness, pain, swelling, color changes (blue or black), and drainage of fluid

• Blood problems. Rebif can affect your bone marrow and cause low red and white blood cell and platelet counts. In some people, these blood cell

continued...
Important Safety Information (continued from previous page)

counts may fall to dangerously low levels. If your blood cell counts become very low, you can get infections and problems with bleeding and bruising. Your healthcare provider may ask you to have regular blood tests to check for blood problems

• **Seizures.** Some people have had seizures while taking Rebif

Rebif will not cure your MS but may decrease the number of flare-ups of the disease and slow the occurrence of some of the physical disability that is common in people with MS.

**Do not take Rebif if you** are allergic to interferon beta, human albumin, or any of the ingredients in Rebif.

**Before you take Rebif, tell your healthcare provider if you have or have had any of the following conditions:**

• mental illness, including depression and suicidal behavior

• liver problems, bleeding problems or blood clots, low blood cell counts, seizures (epilepsy), or thyroid problems

• you drink alcohol

• you are pregnant or plan to become pregnant. It is not known if Rebif will harm your unborn baby. Tell your healthcare provider if you become pregnant during your treatment with Rebif

• you are breastfeeding or plan to breastfeed. It is not known if Rebif passes into your breast milk. You and your healthcare provider should decide if you will use Rebif or breastfeed. You should not do both

**Tell your healthcare provider about all medicines you take,** including prescription and over-the-counter medicines, vitamins and herbal supplements.
The most common side effects of Rebif include:

• flu-like symptoms. You may have flu-like symptoms when you first start taking Rebif. You may be able to manage these flu-like symptoms by taking over-the-counter pain and fever reducers. For many people, these symptoms lessen or go away over time. Symptoms may include muscle aches, fever, tiredness, and chills

• stomach pain

• change in liver blood tests

Tell your healthcare provider if you have any side effects that bother you or that do not go away.

These are not all the possible side effects of Rebif. For more information, ask your healthcare provider or pharmacist.

Call your doctor for medical advice about side effects.
Learn more about strength in numbers at rebif.com, or join the conversation online.

Connect with us on Facebook.
Be sure to “like” us to get started.
facebook.com/mslifelines

Subscribe to our YouTube channel
and always be up to date.
youtube.com/relapsingMStreatment

Search for a live event to attend
in your area at mslifelines.com/events

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