

Treatment Journal

52

weeks to
stay on track

 **Rebif**[®]
(interferon beta-1a)
subcutaneous injection



Tracking your therapy

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.

Questions or comments to discuss with your doctor

What new medications, if any, did you start since your last visit? _____

Any new health care 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'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.

Date: _____

Tips & Doctor Visit Checklist

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

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

Week 1

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

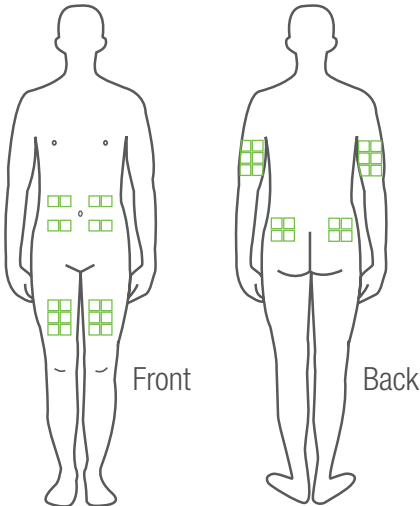
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

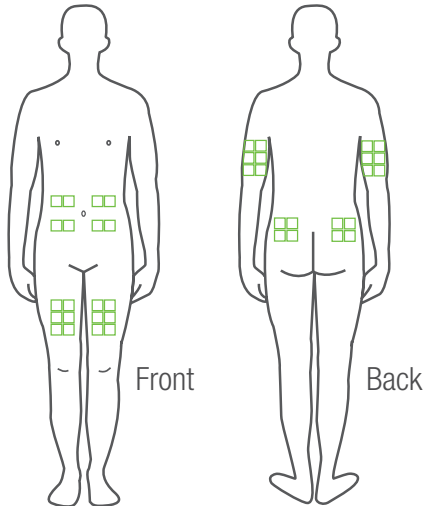
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 2

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

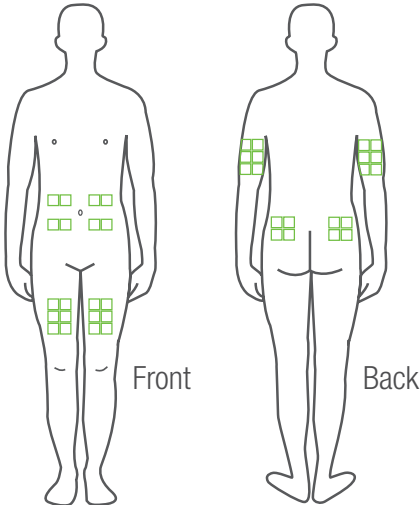
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

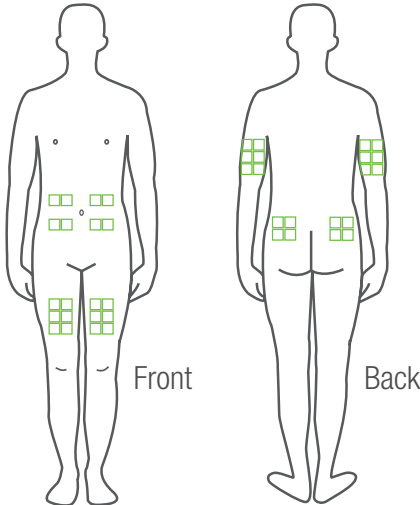
Day: **S M T W T F S**

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

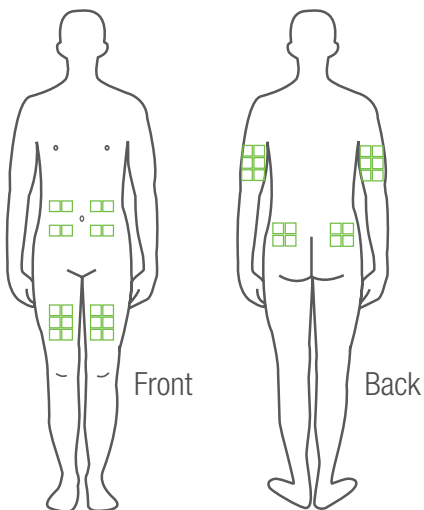
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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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

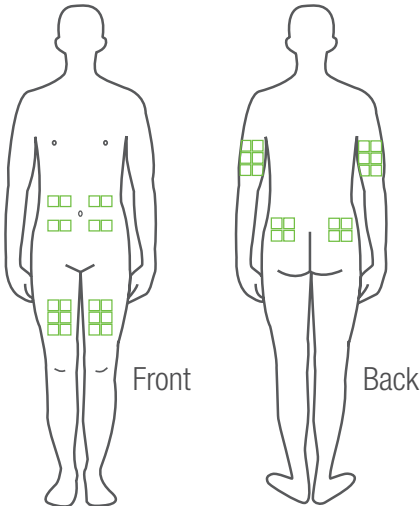
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

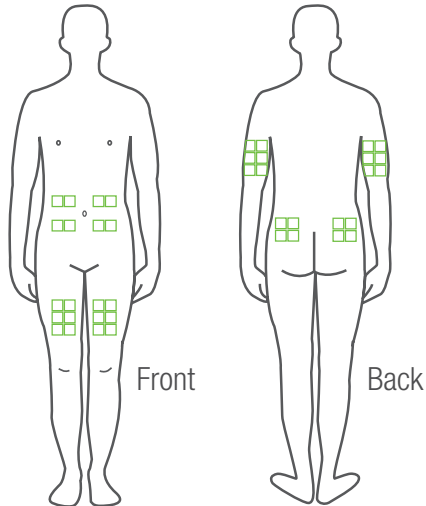
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Injection 3

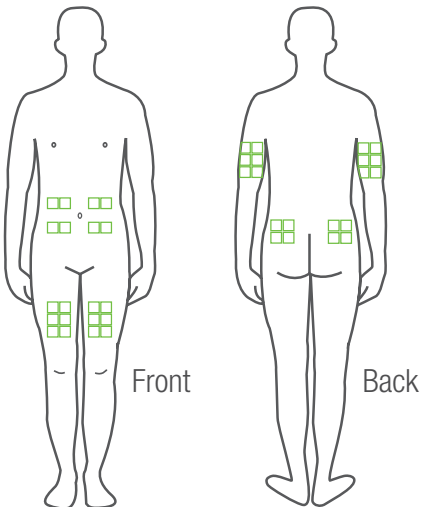
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Week 4

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

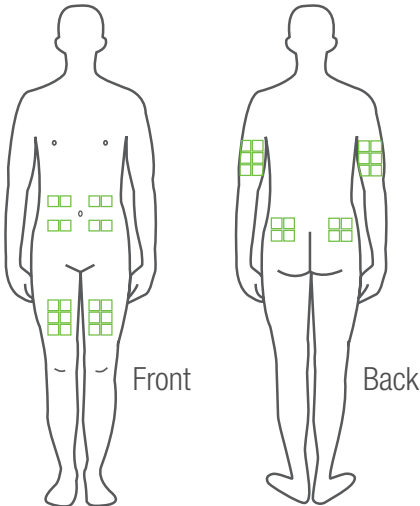
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

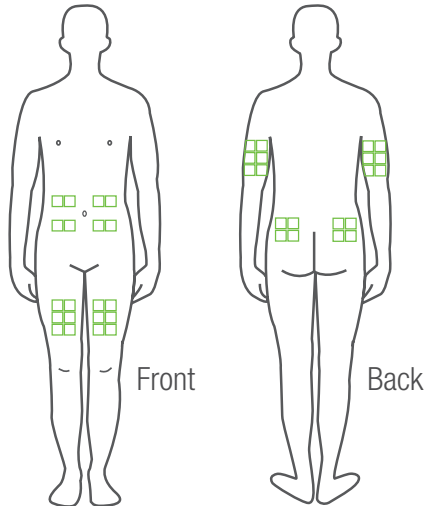
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Injection 3

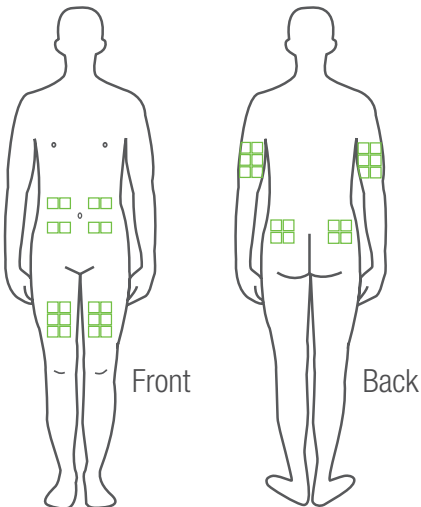
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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Week 5

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

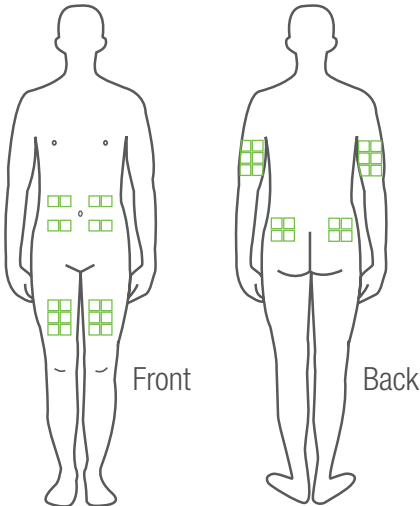
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

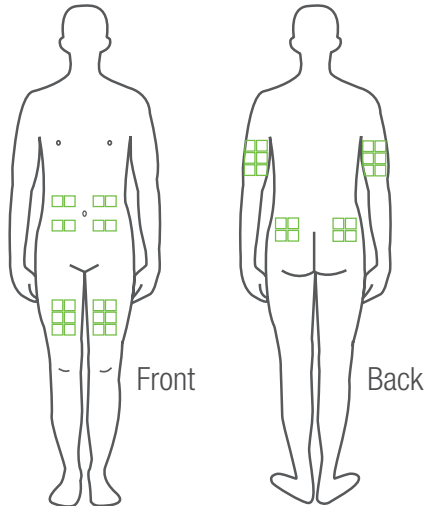
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 6

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

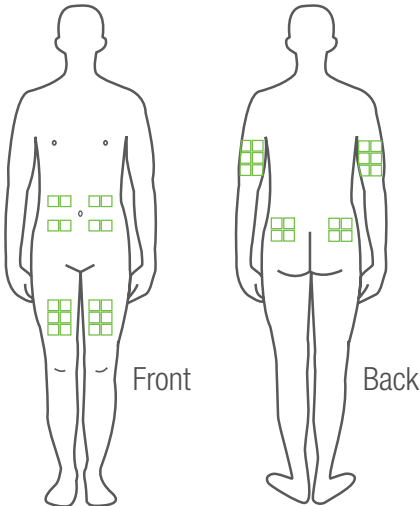
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

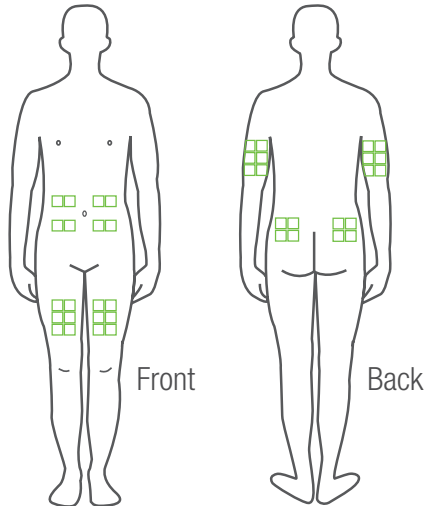
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 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

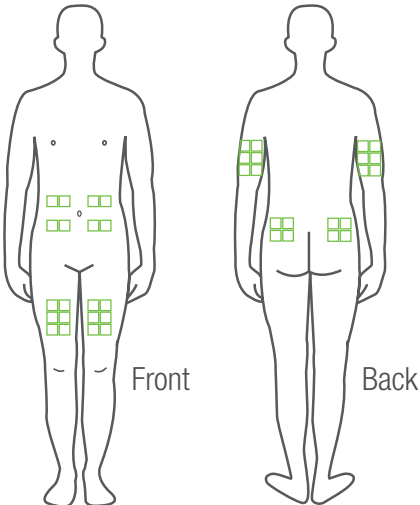
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

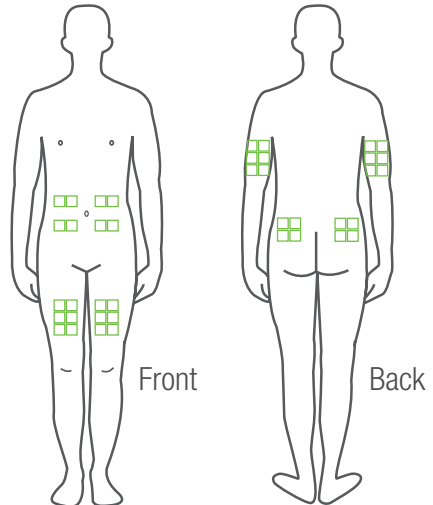
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Injection 3

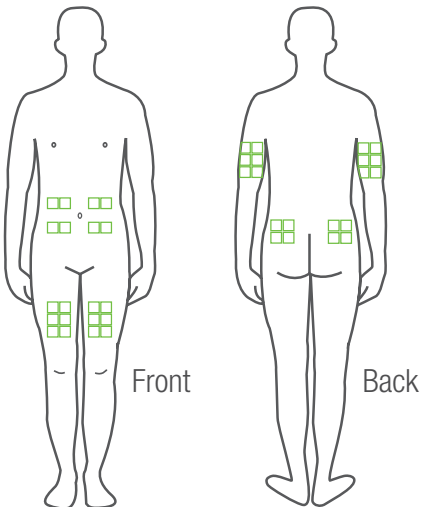
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Week 8

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

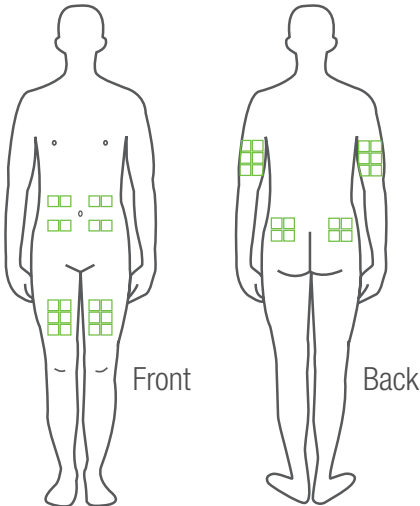
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

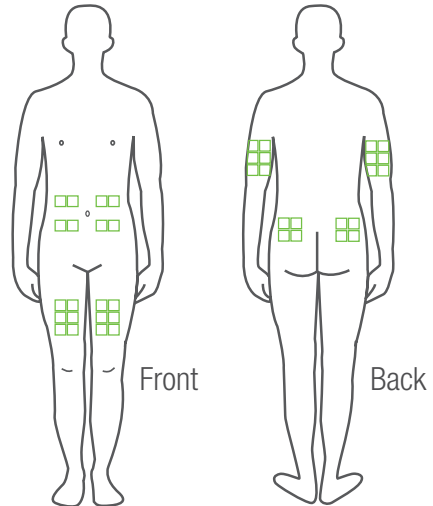
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 9

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

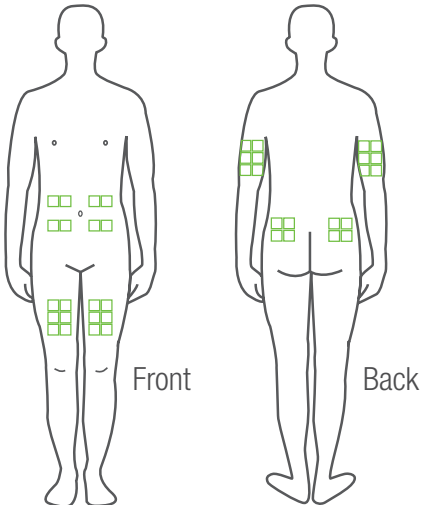
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

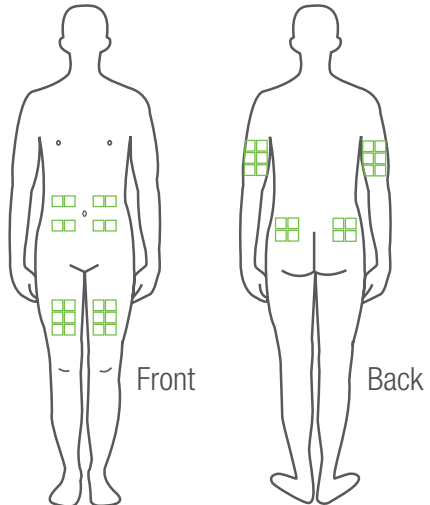
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Injection 3

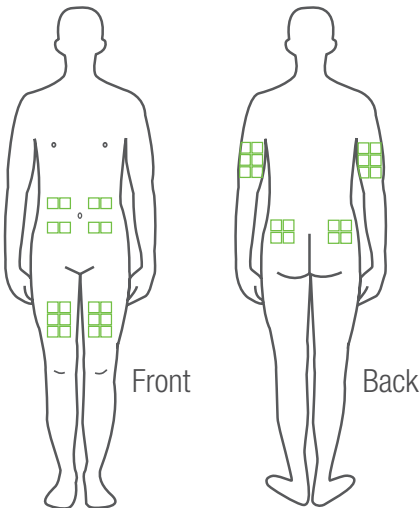
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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Week 10

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

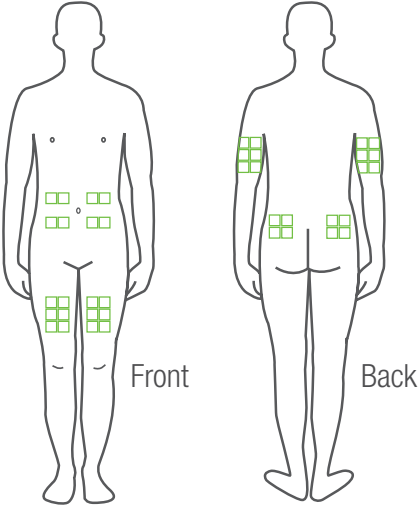
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

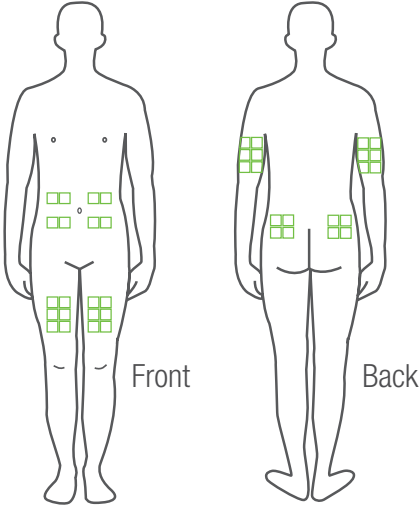
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 11

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

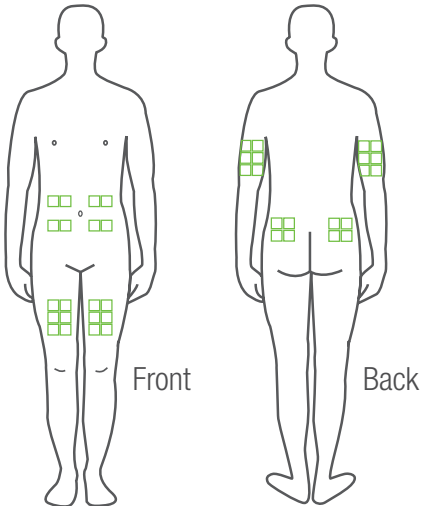
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

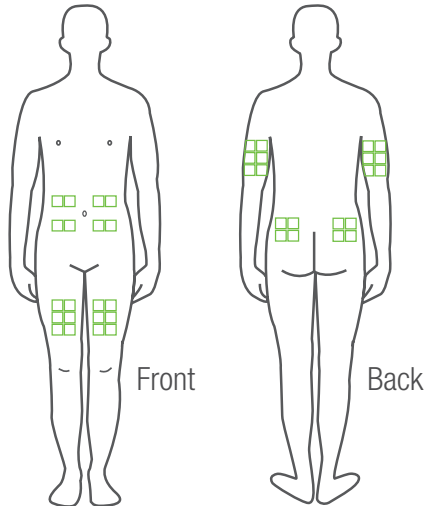
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Injection 3

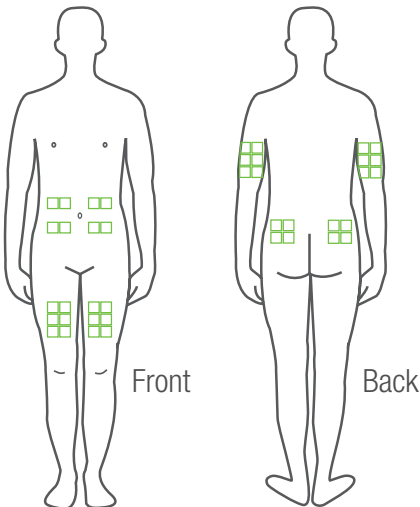
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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Week 12

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

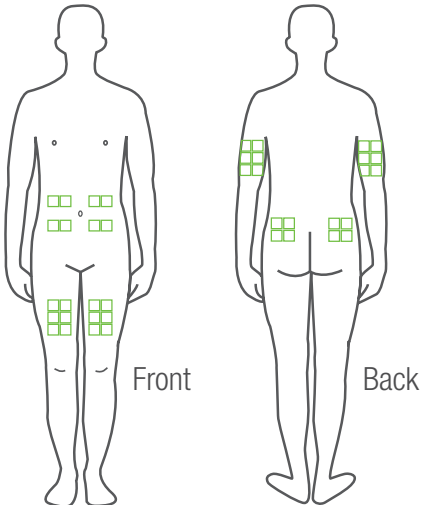
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

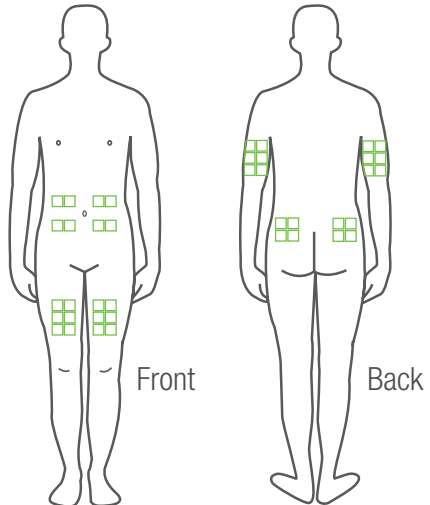
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Injection 3

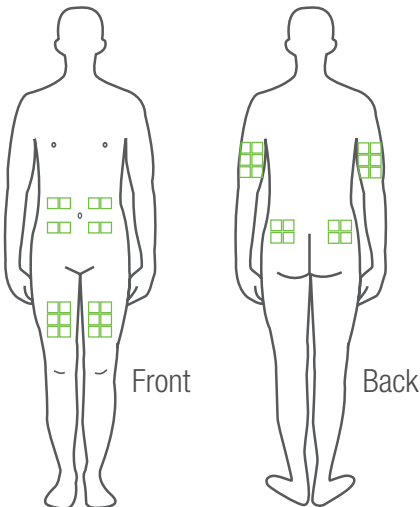
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Week 13

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

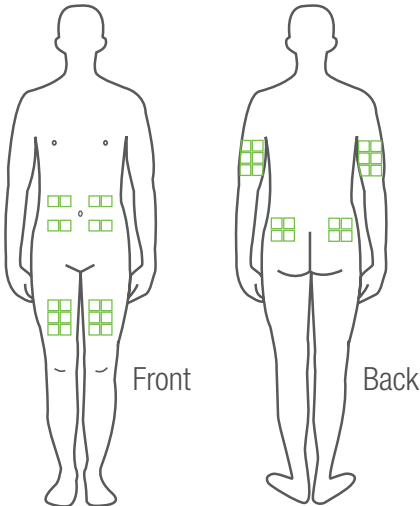
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

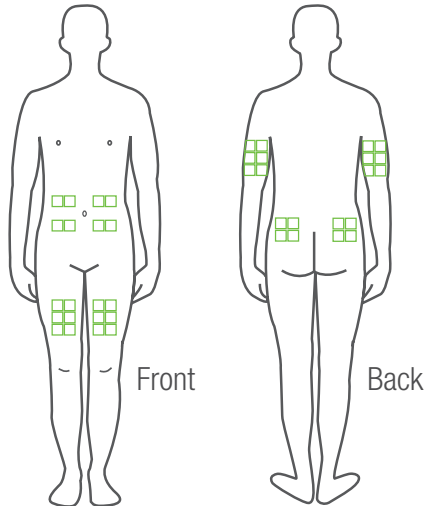
Day: **S M T W T F S**

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

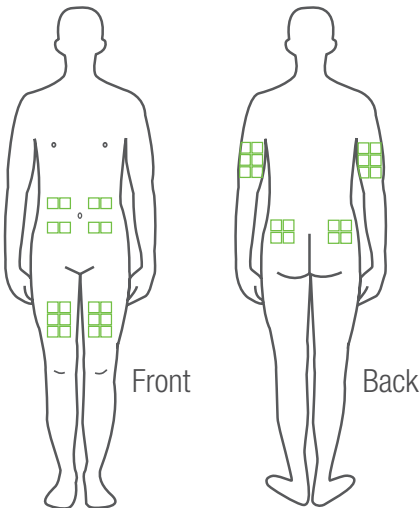
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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Week 14

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

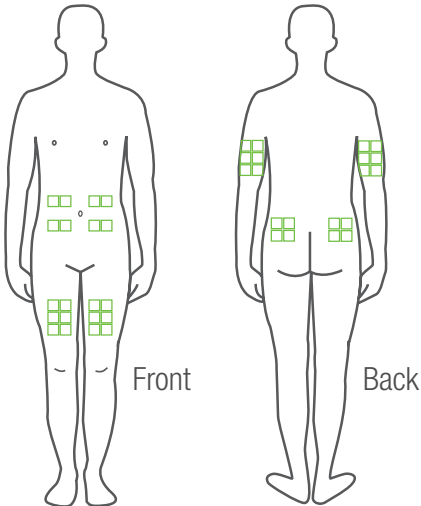
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

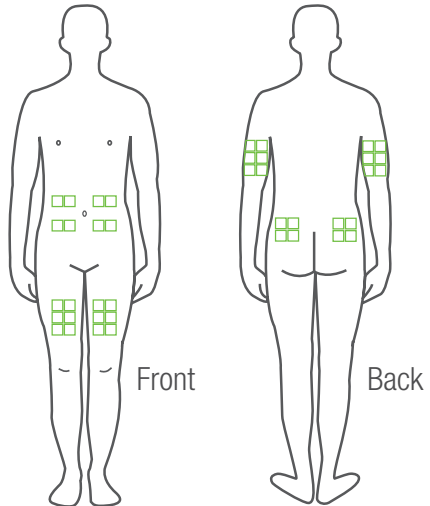
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 15

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

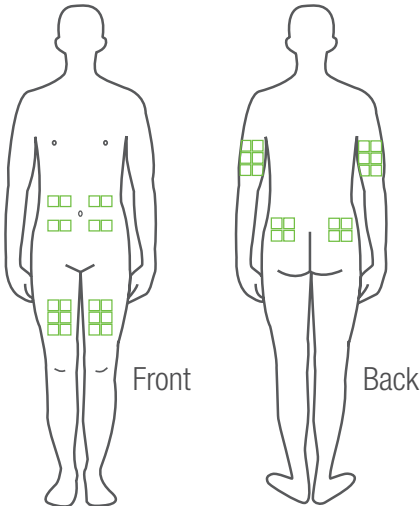
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

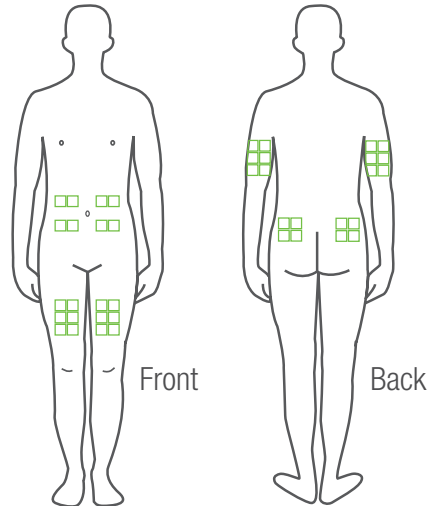
Day: **S M T W T F S**

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

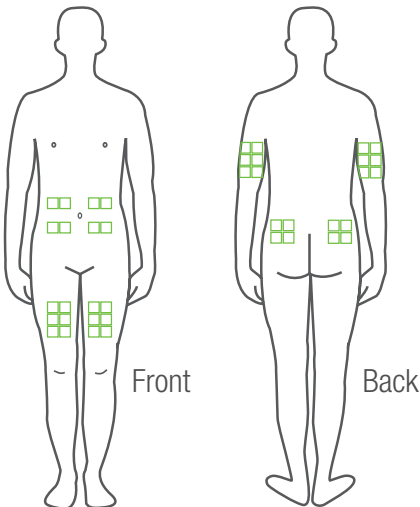
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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Week 16

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

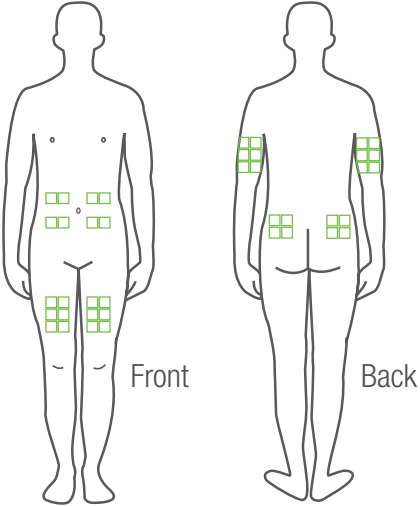
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

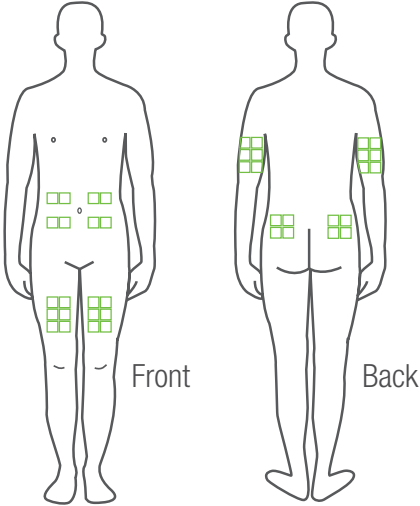
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 17

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

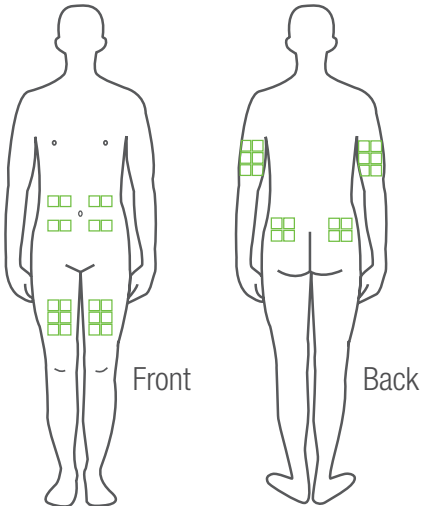
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

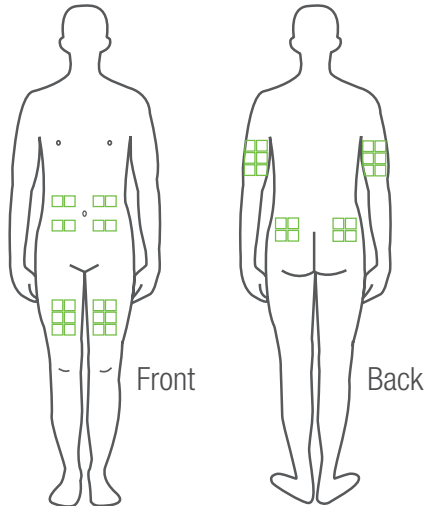
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 18

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

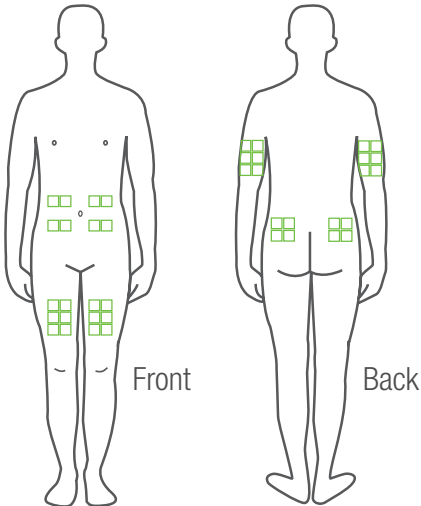
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

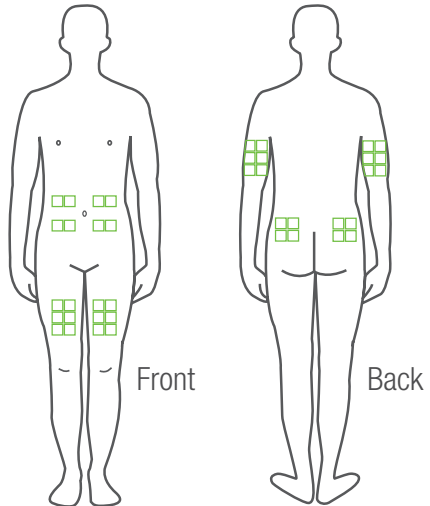
Day: **S M T W T F S**

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

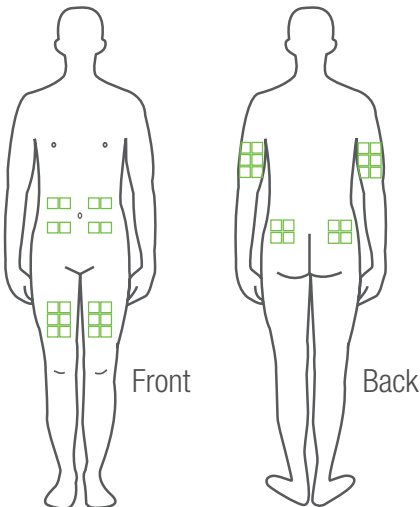
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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

Week 19

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

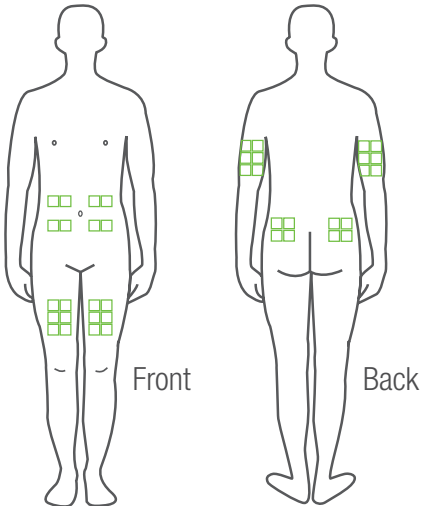
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

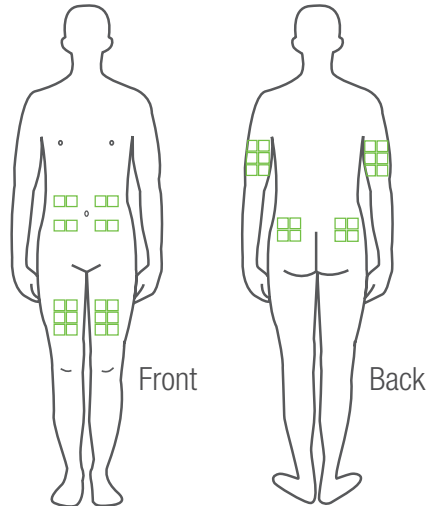
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 20

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

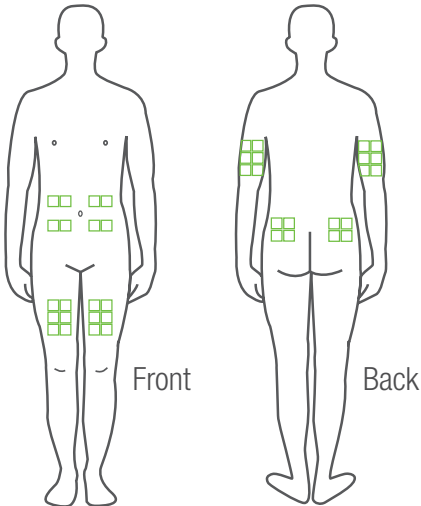
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

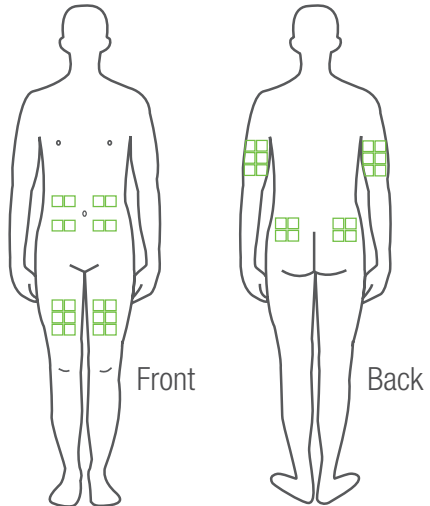
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 21

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

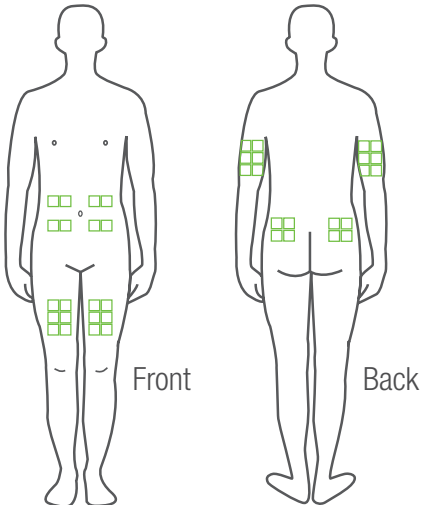
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

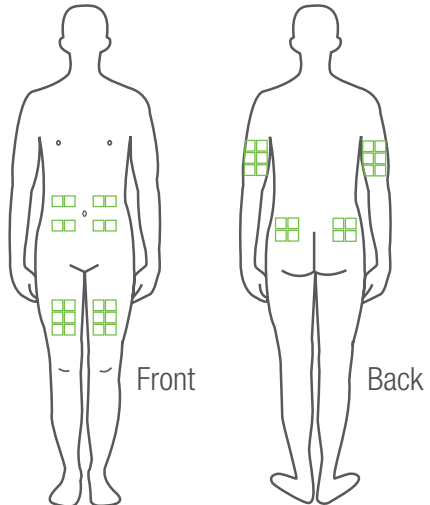
Day: **S M T W T F S**

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

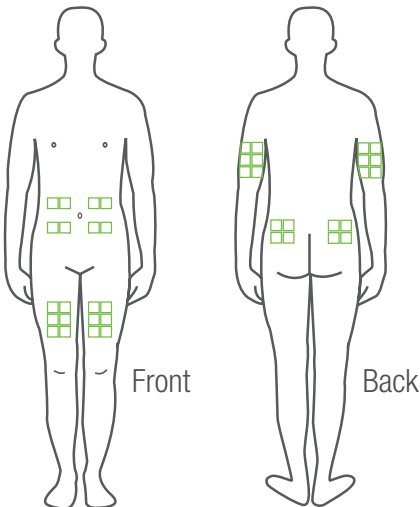
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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

Week 22

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

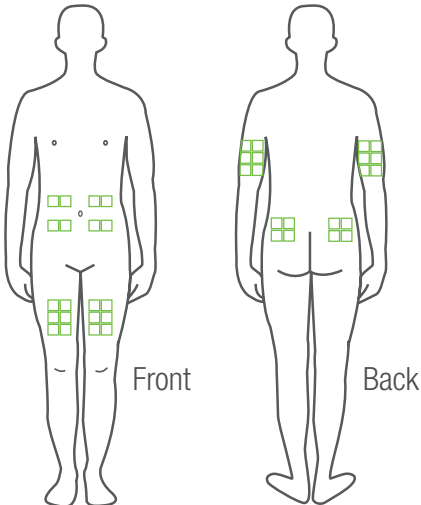
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

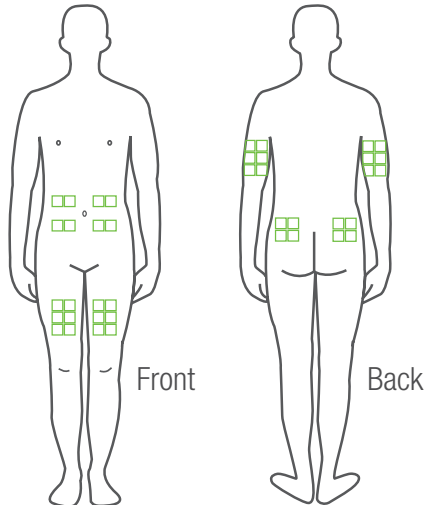
Day: **S M T W T F S**

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

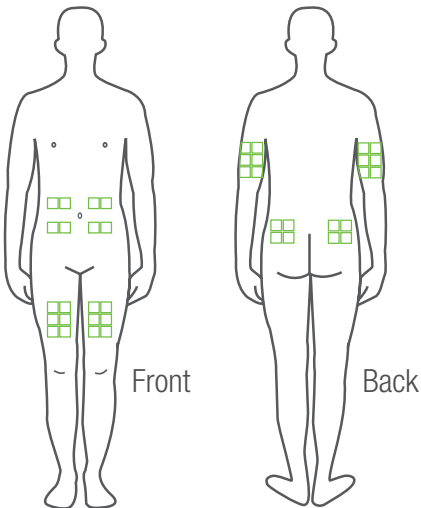
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

Please see
Rebif® (interferon beta-1a)
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pages 119–121.

Week 23

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

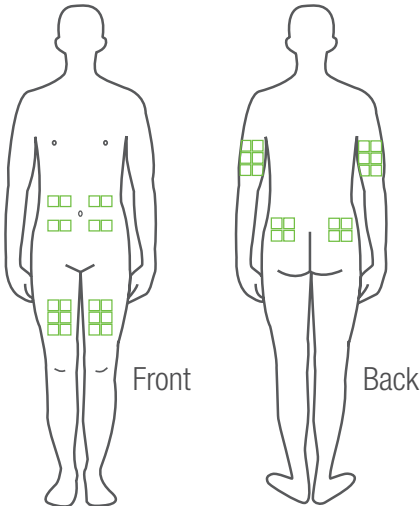
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

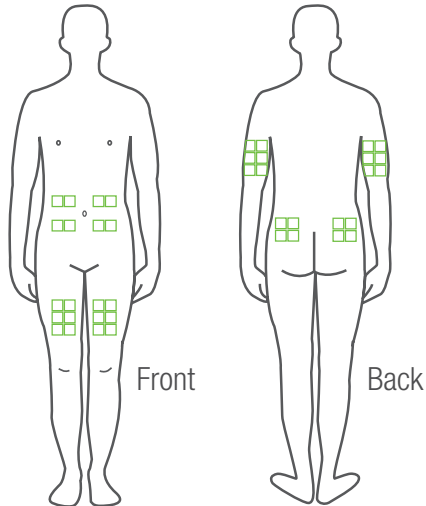
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 24

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

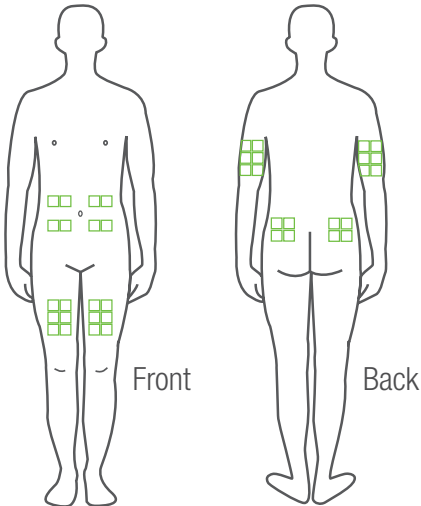
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

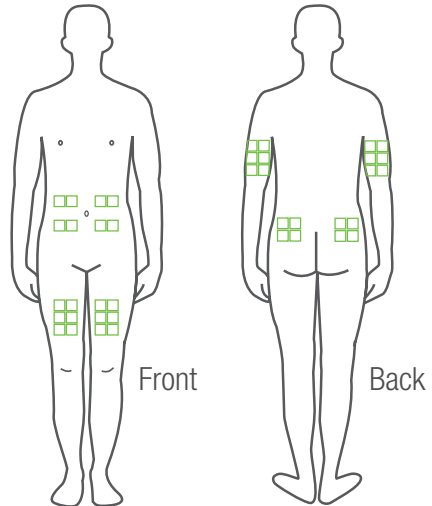
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 25

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

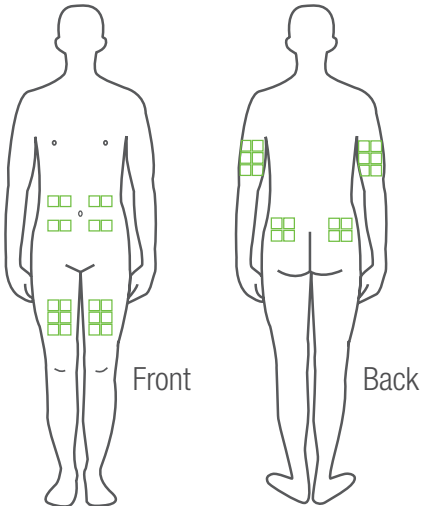
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

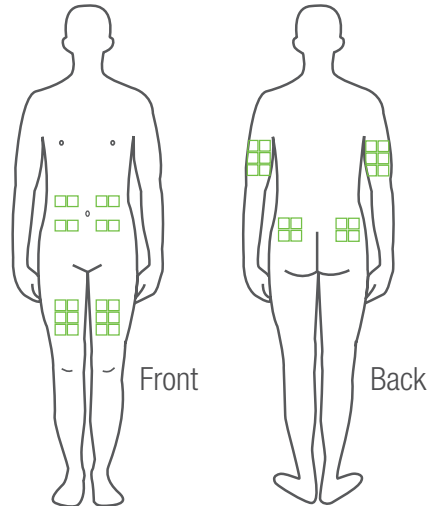
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 26

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

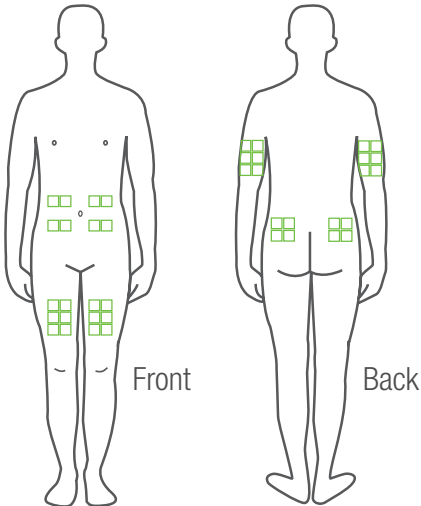
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

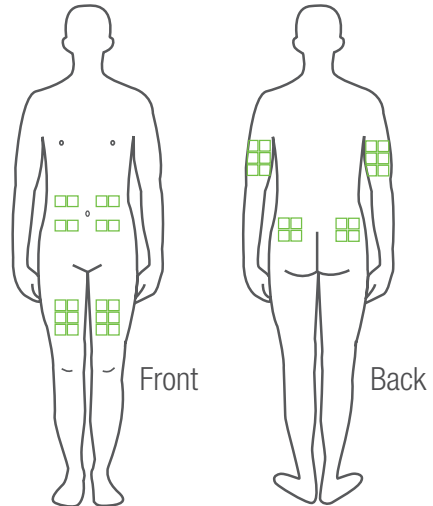
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 27

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

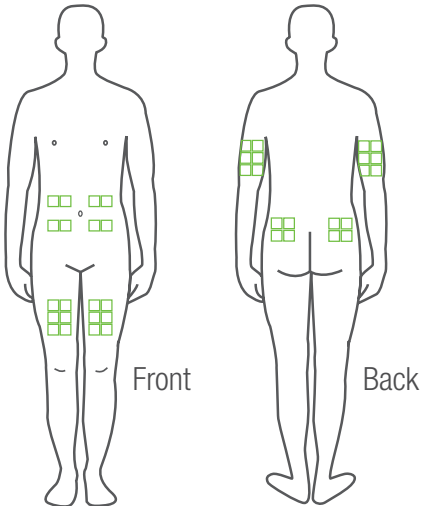
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

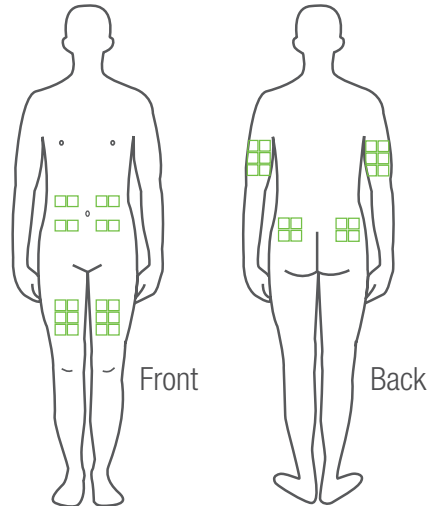
Day: **S M T W T F S**

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

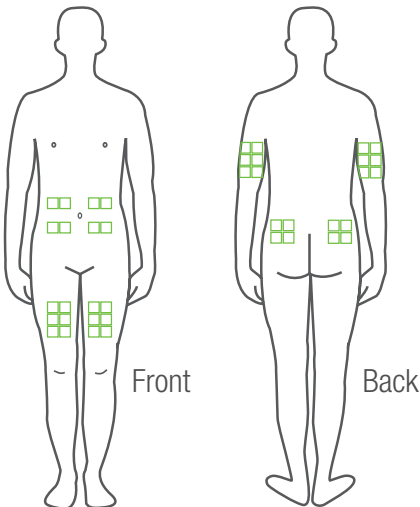
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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

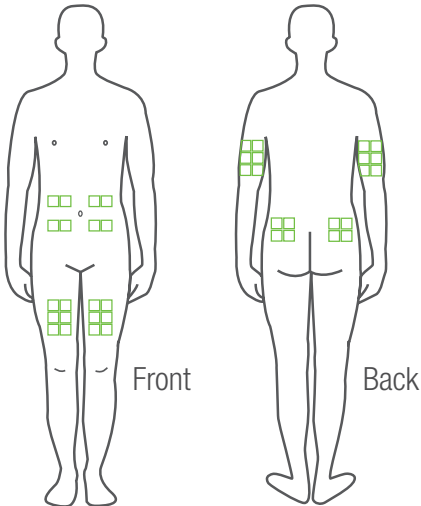
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

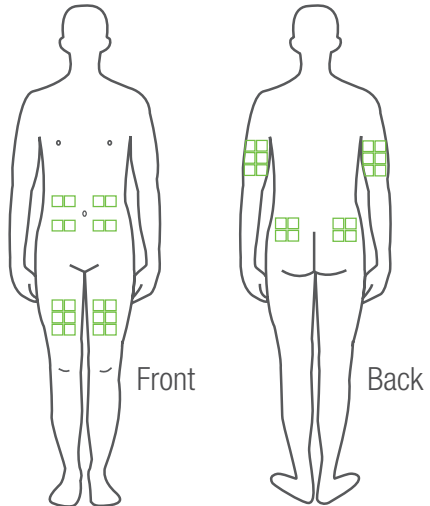
Day: **S M T W T F S**

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

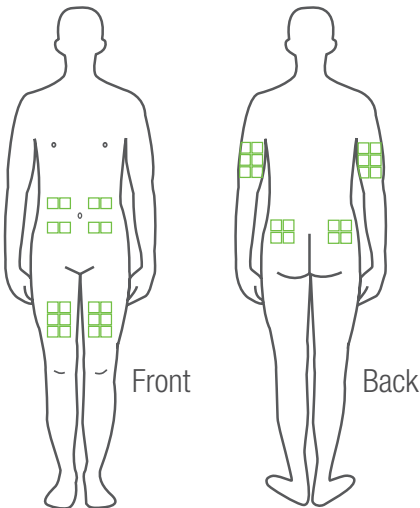
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

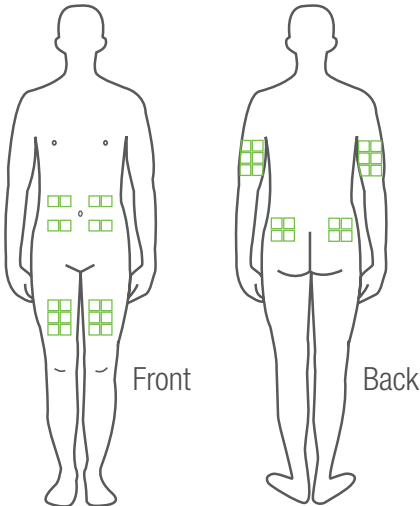
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

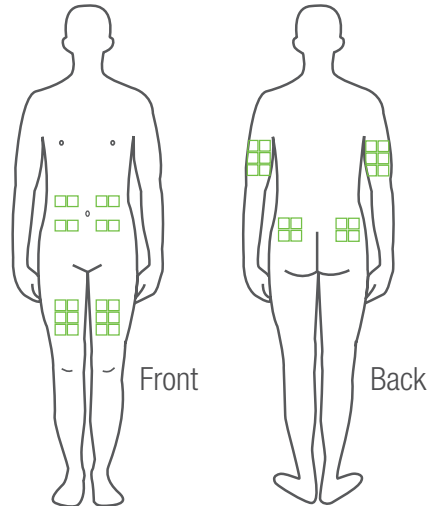
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 30

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

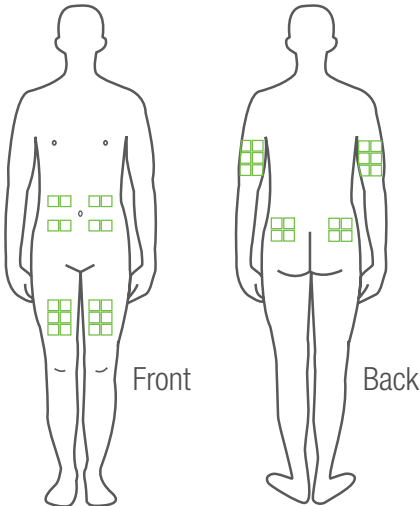
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

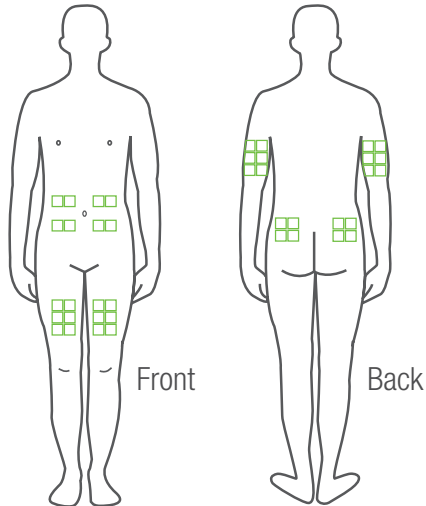
Day: **S M T W T F S**

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

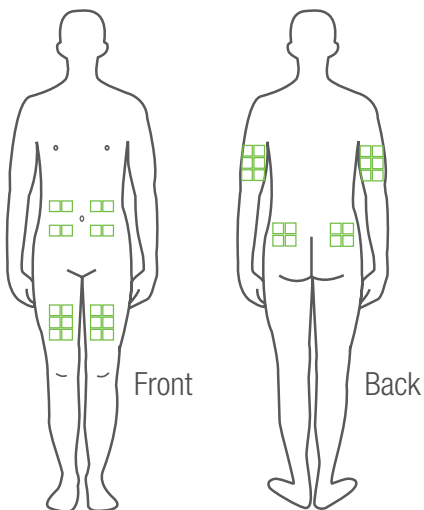
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

Please see
Rebif® (interferon beta-1a)
Prescribing Information and
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pages 119–121.

Week 31

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

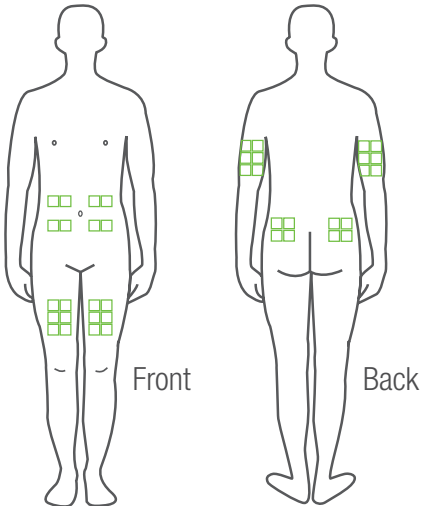
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

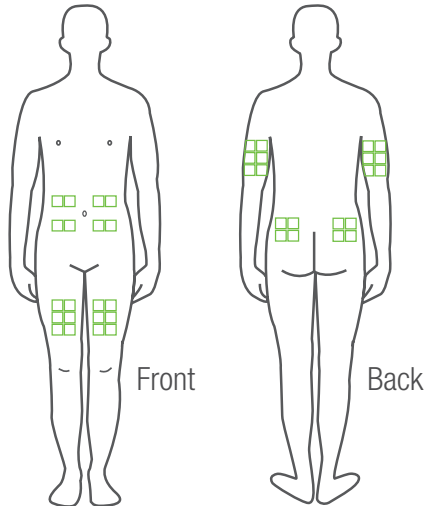
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 32

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

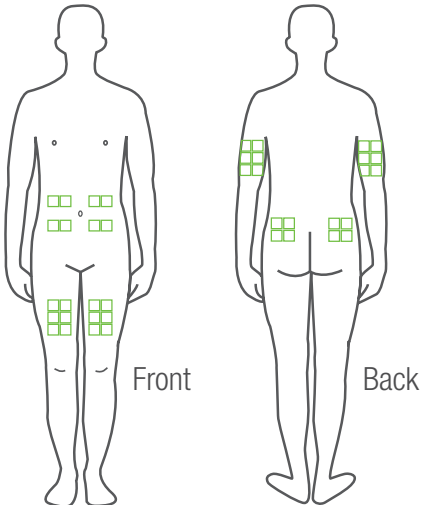
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

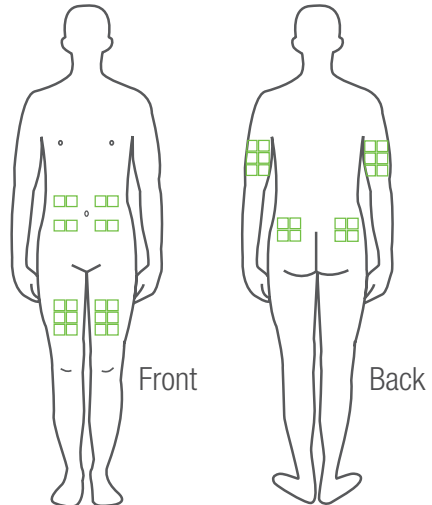
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 33

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

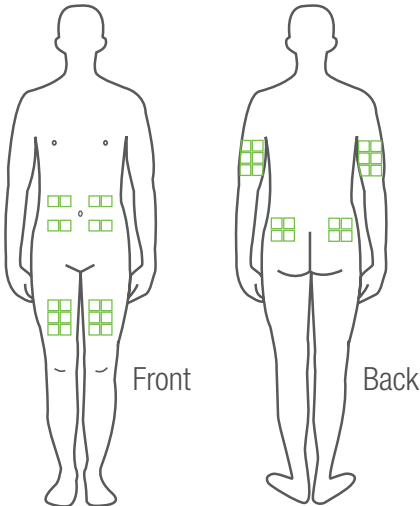
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

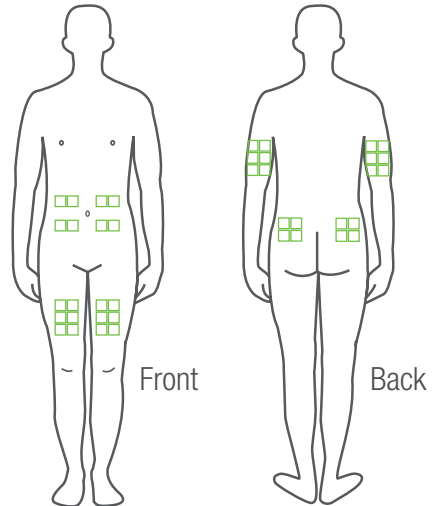
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 34

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

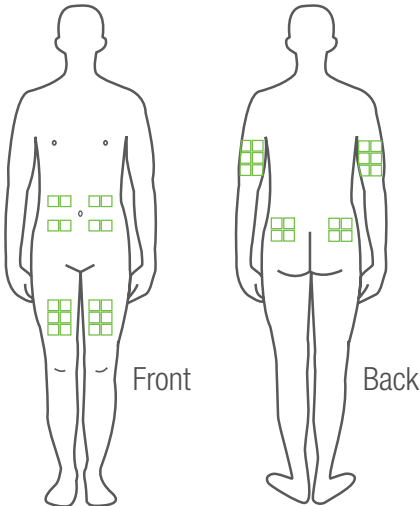
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

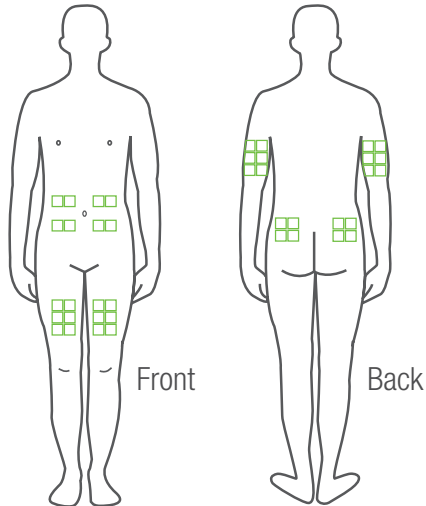
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 35

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

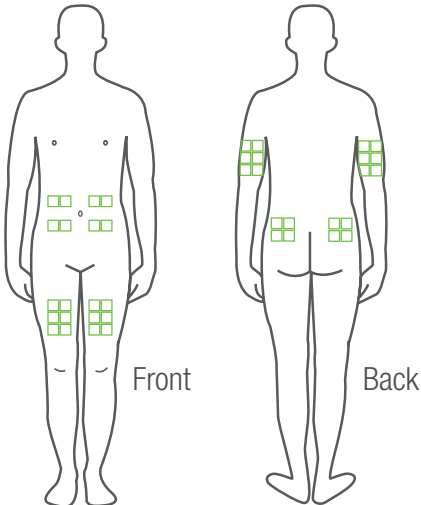
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

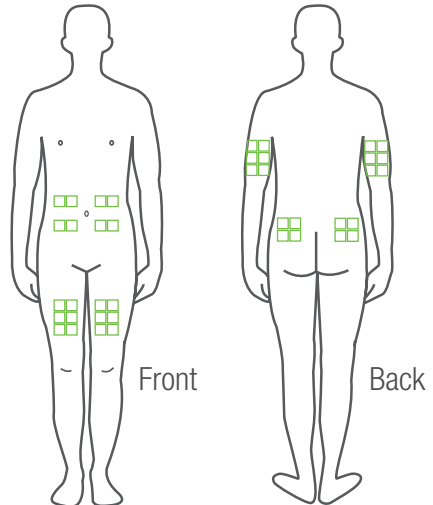
Day: **S M T W T F S**

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

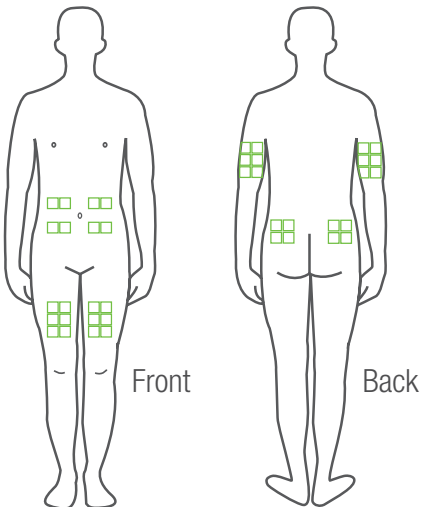
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

Please see
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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

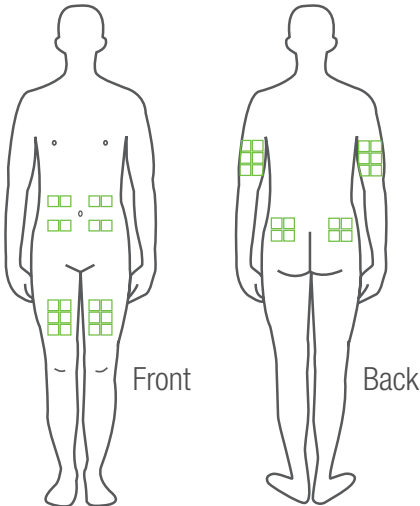
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

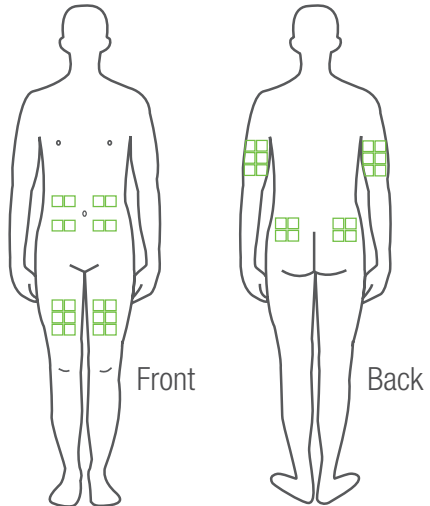
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 37

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

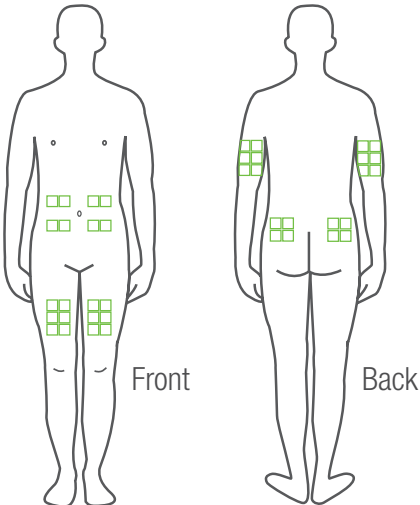
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

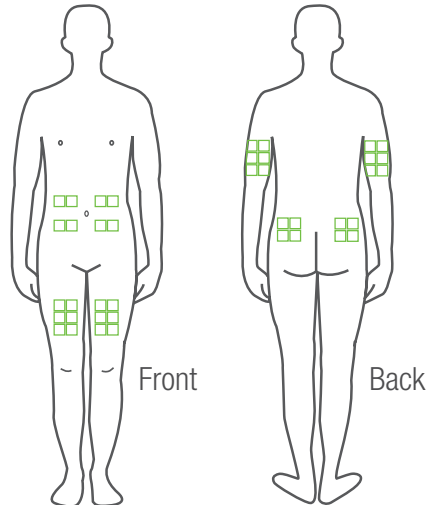
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

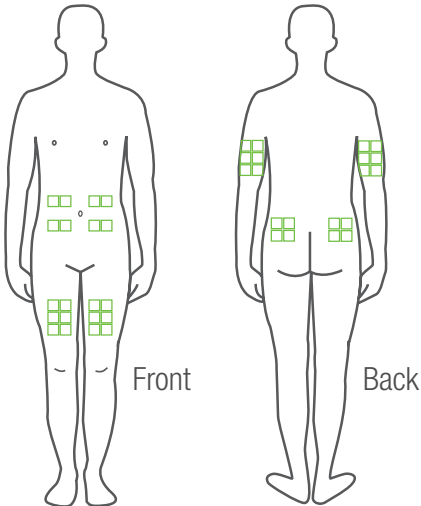
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

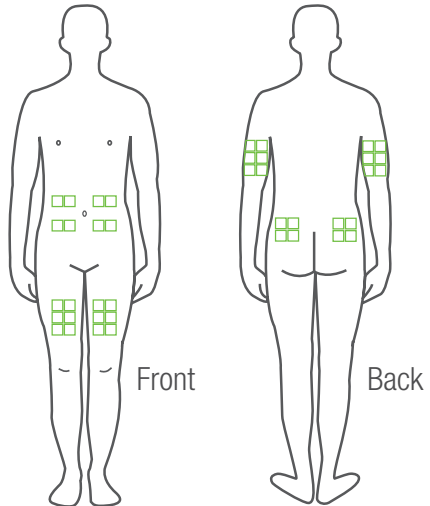
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

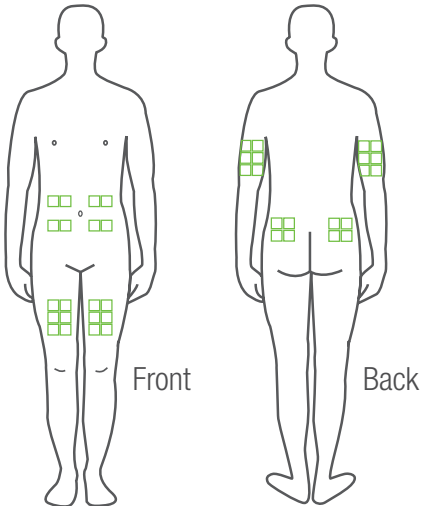
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

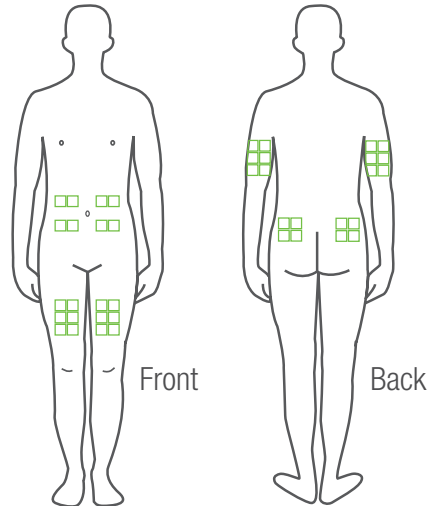
Day: **S M T W T F S**

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

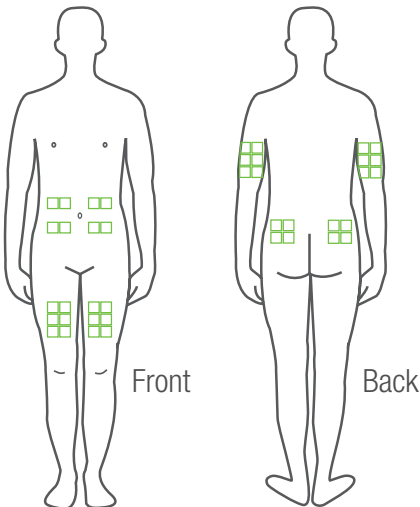
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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

Week 40

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

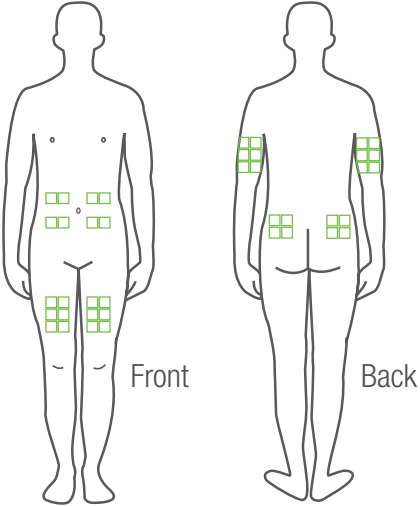
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

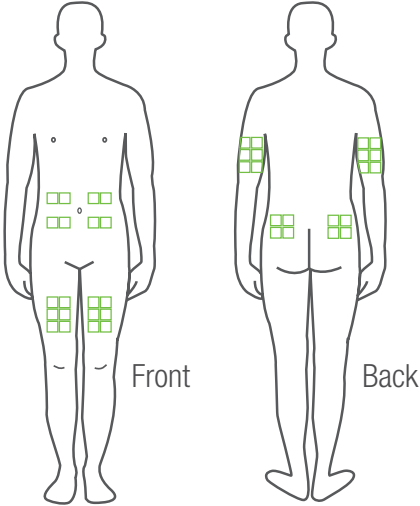
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 41

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

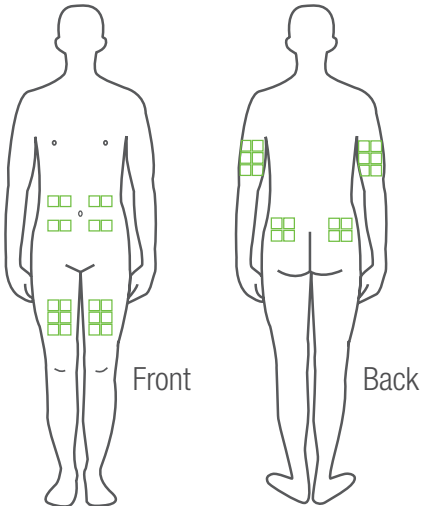
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

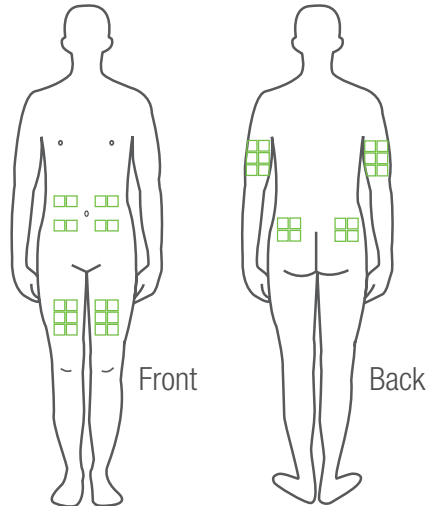
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 42

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

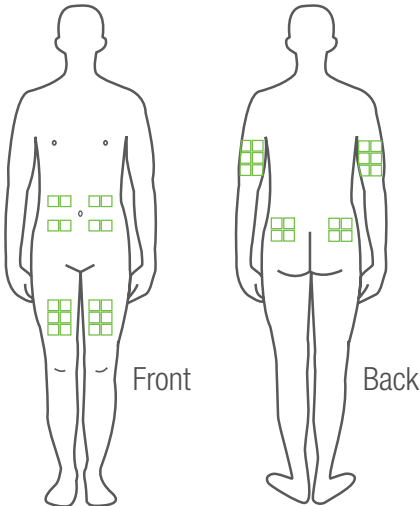
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

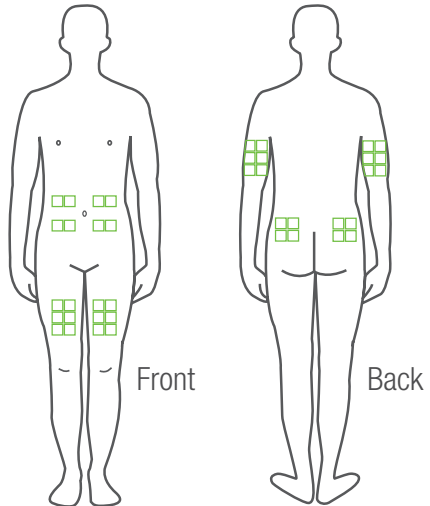
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 43

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

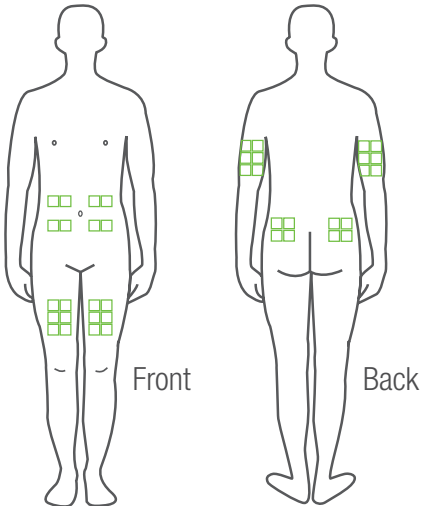
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

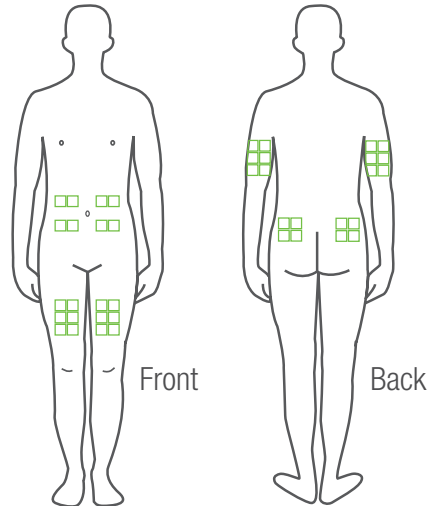
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 44

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

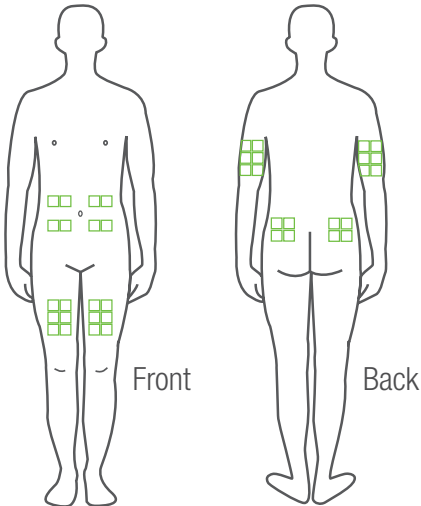
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

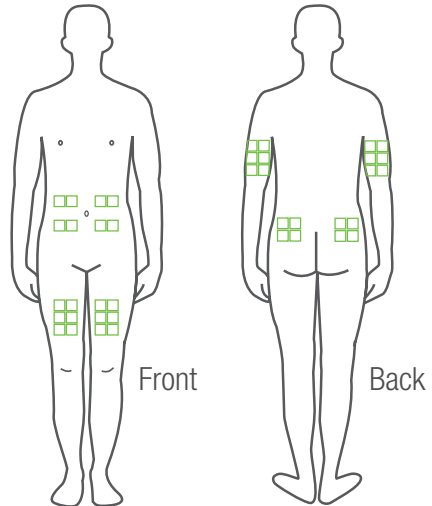
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

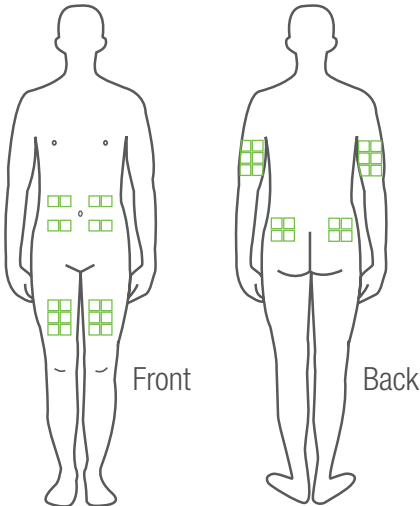
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

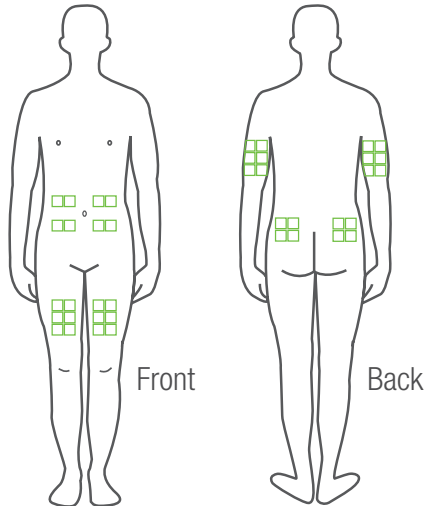
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

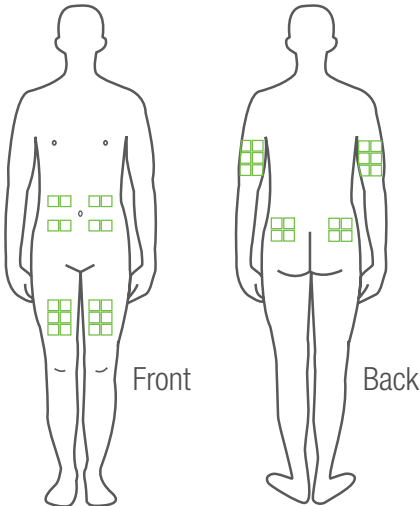
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

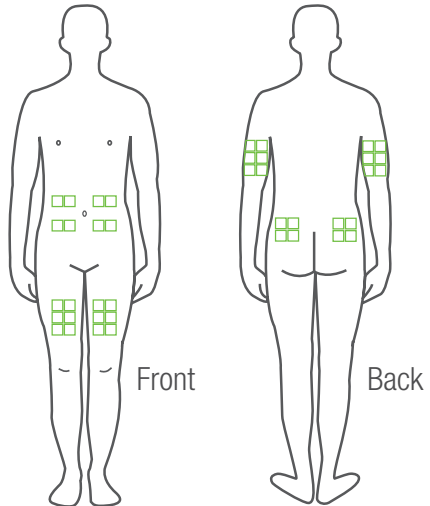
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

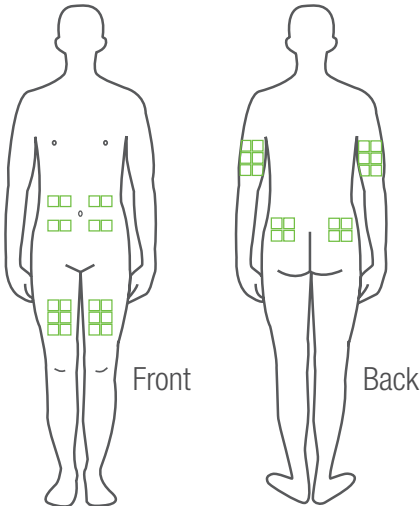
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

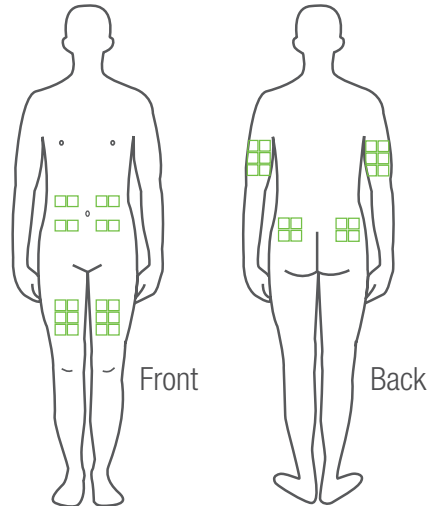
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

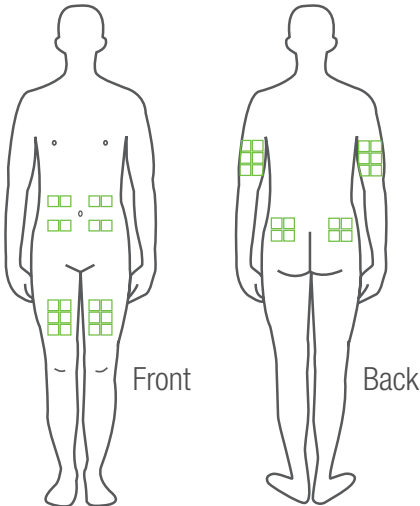
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

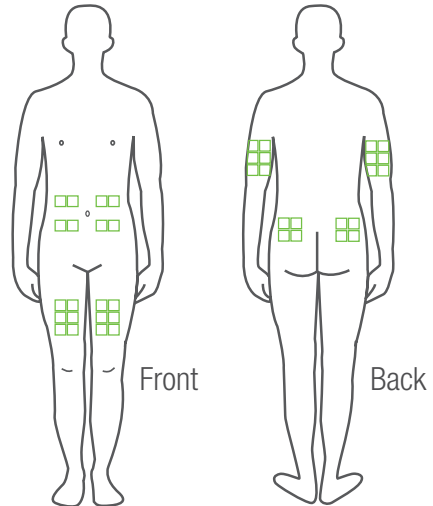
Day: **S M T W T F S**

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

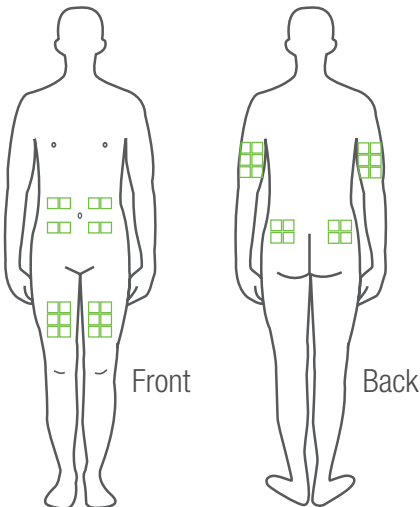
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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

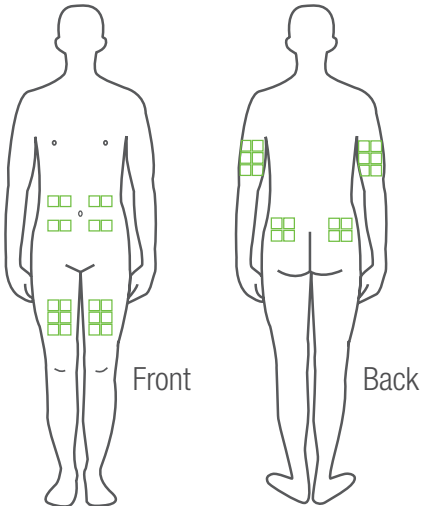
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

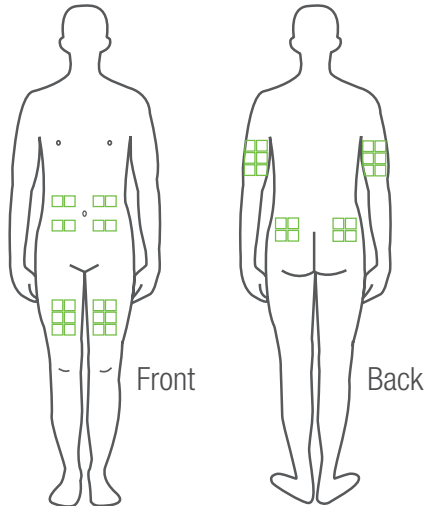
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Week 50

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

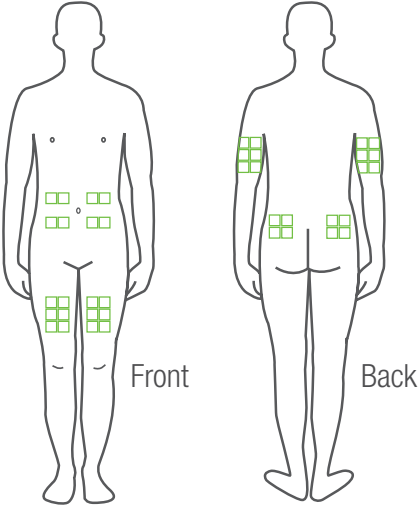
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

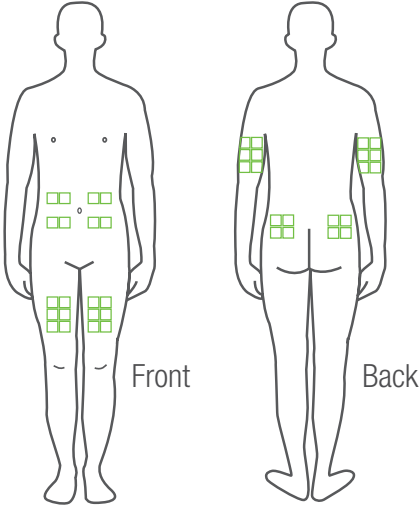
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

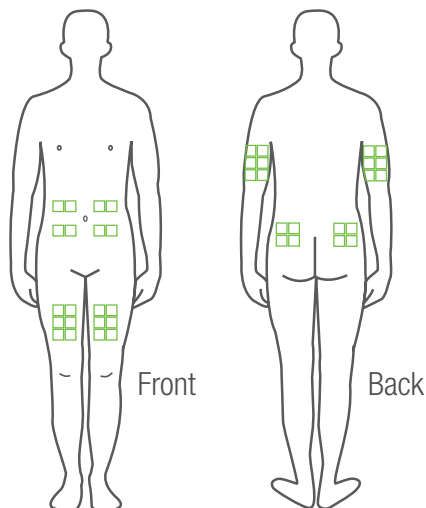
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

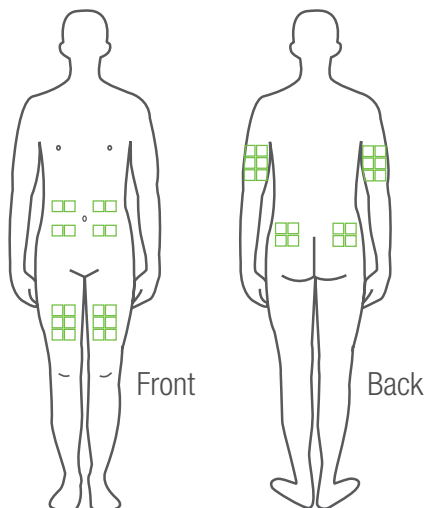
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



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

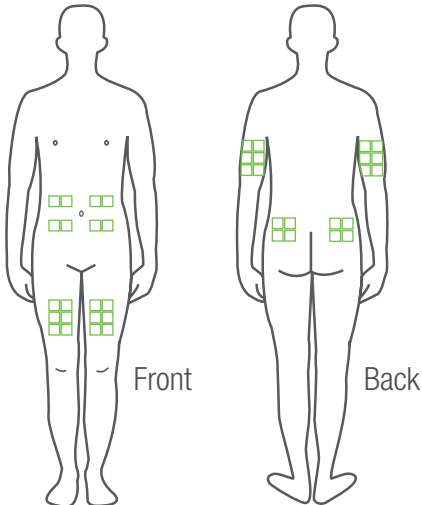
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Injection 2

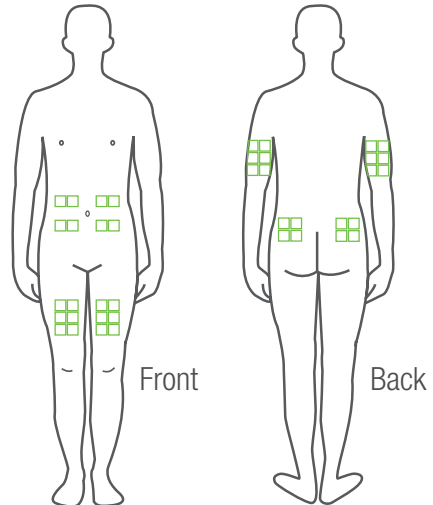
Day: **S M T W T F S**

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

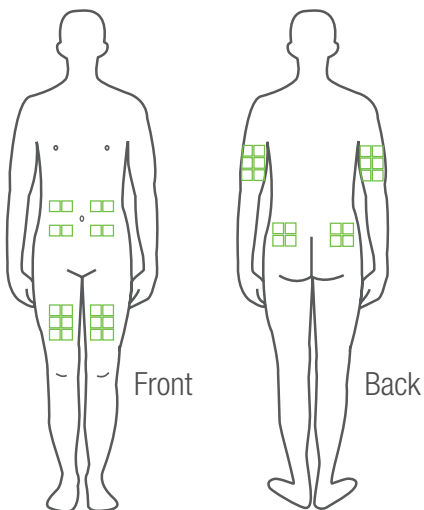
Day: **S M T W T F S**

Date: _____ Time of injection: _____

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

If yes, describe: _____

Injection site



Notes

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

Tips to help manage common side effects

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.

Doctor Visit Checklist

Date: _____

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.

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

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

Date: _____

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.

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

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

Date: _____

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.

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

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

Date: _____

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.

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

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

Date: _____

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.

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

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 _____

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.

Please see Rebif Prescribing Information and Medication Guide enclosed.

The logo for Rebif, featuring a stylized green and blue figure resembling a person or a molecule, followed by the text "Rebif" in a bold, sans-serif font. Below "Rebif" is the text "(interferon beta-1a)" in a smaller, italicized font, and below that is "subcutaneous injection" in a smaller, italicized font.

Rebif[®]
(interferon beta-1a)
subcutaneous injection



Learn more about strength in numbers at rebif.com, or join the conversation online.



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