PRESCRIBER START FORM - GENERALIZED MYASTHENIA GRAVIS (gMG)

FAX: 1.800.420.5150 **MAIL:** 100 College Street New Haven, CT 06510 **PHONE:** 1.888.765.4747 8:30 AM to 8 PM ET Monday–Friday **EMAIL:** OneSource@Alexion.com

ULTOMIRIS (ravulizumab-cwvz) SOLIRIS (eculizumab) ONESOURCE Personalized Patient Support from Alexion

OneSource™ is a complimentary, personalized patient support program offered by Alexion. It's designed to support patients' specific needs throughout treatment. For more information, visit www.AlexionOneSource.com. Contact OneSource if you have any questions while completing the forms.

INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS

To enroll your patient in OneSource, please follow these steps:

1. Have your patient complete all required sections and read the Authorization to Share Health Information on the **Patient Services Enrollment Form**
2. Complete all required sections on **PAGE 1**
3. Sign the Prescriber Certification on **PAGE 2**
4. **FAX PAGES 1-2 of the completed enrollment form and copies of the front and back of the patient's insurance and pharmacy coverage cards** to OneSource

Fields in red with asterisks are required.*

STEP 1: PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)*	DATE OF BIRTH (MM/DD/YYYY)*	PATIENT PHONE NUMBER*	PATIENT EMAIL

STEP 2: CLINICAL DIAGNOSIS

SOLIRIS and ULTOMIRIS are FDA approved for antibody positive status. If a payer requires prior authorization and/or has a clinical policy, they may require proof of antibody status.

INDICATION*: ☐ GENERALIZED MYASTHENIA GRAVIS (gMG)
ICD-10: ☐ G70.00 Myasthenia gravis without (acute) exacerbation
☐ G70.01 Myasthenia gravis with (acute) exacerbation

ANTIBODY STATUS (select one)*: ☐ ANTI-AChR ANTIBODY POSITIVE (gMG)
☐ UNKNOWN (CONTACT ONESOURCE FOR QUESTIONS)

STEP 3: INSURANCE INFORMATION

Complete this section OR attach copies of patient's medical and pharmacy insurance card(s).*

☐ PLEASE PROVIDE SUMMARY OF BENEFIT INVESTIGATION FOR ULTOMIRIS AND SOLIRIS

☐ COPIES OF PATIENT INSURANCE CARD(S) ATTACHED ☐ PATIENT DOES NOT HAVE INSURANCE	PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE	PHARMACY COVERAGE
INSURANCE PROVIDER*			
INSURANCE PHONE #*			
CARDHOLDER NAME*			
CARDHOLDER DATE OF BIRTH*			
MEMBER ID*			
POLICY #*			
GROUP #*			
BIN/PCN #			

STEP 4: HEALTHCARE PRESCRIBER INFORMATION

FIRST NAME*	LAST NAME*	PROVIDER EMAIL*
ADDRESS*		PHONE NUMBER*
CITY*	STATE*	ZIP*
PRACTICE NAME	TAX ID #*	NPI #*
OFFICE CONTACT NAME	EMAIL	FAX NUMBER*

STEP 5: SITE OF CARE

SELECT OPTION A OR B BELOW*:

☐ **A) PLEASE PROVIDE ASSISTANCE LOCATING AN INFUSION SITE.** PLEASE COORDINATE DIRECTLY WITH: ☐ HEALTHCARE PROVIDER ☐ PATIENT

☐ **B) ASSISTANCE IS NOT NEEDED.** PATIENT WILL BE INFUSED AT: ☐ PRESCRIBER'S OFFICE ☐ PATIENT'S HOME ☐ PREFERRED INFUSION SITE (PLEASE SPECIFY BELOW)

SITE OF CARE NAME	NPI #	TAX ID #
ADDRESS		
CITY	STATE	ZIP
OFFICE CONTACT FOR FOLLOW-UP		PHONE NUMBER

Please see Indications & Important Safety Information on page 4 and accompanying full Prescribing Information and Medication Guide for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis, also available on www.ULTOMIRIS.com.

Please see Indications & Important Safety Information on page 5 and accompanying full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

PRESCRIBER START FORM - GENERALIZED MYASTHENIA GRAVIS (gMG)

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ULTOMIRIS (ravulizumab-cwvz) SOLIRIS (eculizumab) ONESOURCE Personalized Patient Support from Alexion

Fields in red with asterisks are required.*

PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)* | DATE OF BIRTH (MM/DD/YYYY)*

STEP 6: CLINICAL INFORMATION

CHECK ALL PREVIOUS GENERALIZED MYASTHENIA GRAVIS (gMG) THERAPIES:

☐ AZATHIOPRINE ☐ MYCOPHENOLATE MOFETIL ☐ PREDNISONE ☐ RITUXIMAB ☐ OTHER
☐ IVIg ☐ PLASMAPHERESIS ☐ PYRIDOSTIGMINE ☐ EFGARTIGIMOD

MGFA CLASSIFICATION: _____ CURRENT MG-ADL SCORE: _____

Abbreviations: gMG, generalized myasthenia gravis; IVIg, intravenous immunoglobulin; MG-ADL, Myasthenia Gravis Activities of Daily Living; MGFA, Myasthenia Gravis Foundation of America.

STEP 6: PRESCRIPTION

YOU MAY USE THIS SECTION TO PROVIDE A PRESCRIPTION FOR ULTOMIRIS OR SOLIRIS, OR YOU MAY PROVIDE A SEPARATE PRESCRIPTION.

☐ Rx **ULTOMIRIS** 100 mg/mL HCPCS CODE: J1303 PER UNIT
PATIENT WEIGHT: _____

LOADING DOSE:
SIG: INFUSE INTRAVENOUSLY _____ mg ON DAY 0. COVERS THE PATIENT FOR THE FIRST 2 WEEKS.
☐ OTHER: _____
QTY OF 300 mg/3 mL VIALS: _____
REFILLS: 0

MAINTENANCE DOSE:
SIG: INFUSE INTRAVENOUSLY _____ mg EVERY _____ WEEKS. START 2 WEEKS AFTER COMPLETION OF LOADING DOSE.
☐ _____
QTY OF 300 mg/3 mL VIALS: _____
REFILLS: _____
QTY OF 1100 mg/11 mL VIALS: _____
REFILLS: _____

☐ Rx **SOLIRIS** 10 mg/mL HCPCS CODE: J1300 PER UNIT

LOADING DOSE:
SIG: INFUSE INTRAVENOUSLY _____ mg WEEKLY FOR THE FIRST 4 WEEKS, FOLLOWED BY _____ mg FOR THE 5TH WEEK.
☐ OTHER: _____
QTY OF 300 mg/30 mL VIALS: _____
REFILLS: 0

MAINTENANCE DOSE:
SIG: INFUSE INTRAVENOUSLY _____ mg EVERY 2 WEEKS. START 2 WEEKS AFTER THE 5TH WEEK'S DOSE IS COMPLETE.
☐ OTHER: _____
QTY OF 300 mg/30 mL VIALS: _____
REFILLS: _____

HAS YOUR PATIENT RECEIVED ANY DOSES OF A MENINGOCOCCAL VACCINE OR ANTIBIOTIC PROPHYLAXIS? IF SO, PLEASE PROVIDE RELEVANT INFORMATION. *See ACIP guidelines below.**

Alexion complement-inhibitor therapies are available only through a restrictive program under a Risk Evaluation and Mitigation Strategy (REMS). Vaccination dates provided as part of this form are used to confirm vaccination prior to starting treatment.

YES

Antibiotic prophylaxis administered? ☐ Yes ☐ No
If yes, date: ___/___/___

Patient has received or is scheduled to receive the required vaccinations per ACIP guidelines. Please complete the following information:

MenACWY

1st Dose Date: ___/___/___
Mfr: ☐ Menveo ☐ Menactra ☐ MenQuadfi

2nd Dose Date: ___/___/___
Mfr: ☐ Menveo ☐ Menactra ☐ MenQuadfi

SIGN THE PRESCRIBER CERTIFICATION BELOW AND SKIP PAGE 3

MenB

1st Dose Date: ___/___/___
Mfr: ☐ Bexsero ☐ Trumenba

2nd Dose Date: ___/___/___
Mfr: ☐ Bexsero ☐ Trumenba

3rd Dose Date: ___/___/___
(3rd dose - Trumenba ONLY)

NO

☐ Patient needs **VACCINATION SUPPORT** from OneSource:

✓ **Sign prescriber certification below**

✓ Continue to **PAGE 3** to fill out a **vaccination prescription**†

*The current ACIP guidelines recommend a regimen of MenACWY AND MenB doses prior to starting a complement inhibitor treatment.
†You may also provide a separate prescription.

STEP 8: PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) I am prescribing ULTOMIRIS or SOLIRIS for the patient identified above based on my clinical judgment that it is medically necessary for the diagnosis identified on this form and I will be supervising the patient's treatment; (ii) I am authorized under applicable law to prescribe ULTOMIRIS or SOLIRIS and I have verified and complied with all applicable prescription requirements; (iii) I am authorizing Alexion to forward the patient's prescription to a pharmacy; (iv) I am under no obligation to prescribe ULTOMIRIS or SOLIRIS and I have not received, nor will I receive, any benefit from Alexion for prescribing ULTOMIRIS or SOLIRIS; and (v) the information provided on this form is complete, current, and accurate to the best of my knowledge. I also acknowledge that Alexion will use and share the personal data collected about me (as the prescriber) in accordance with the Privacy Notice on the Alexion website at https://alexion.com/Legal#privacy.

SIGN ONE*

PRESCRIBER'S SIGNATURE (NO STAMPS) - **DISPENSE AS WRITTEN** DATE (MM/DD/YYYY)

PRESCRIBER'S SIGNATURE (NO STAMPS) - **MAY SUBSTITUTE** DATE (MM/DD/YYYY)

Please verify your local prescribing requirements (eg, New York prescribers must provide a separate prescription).

Please see Indications & Important Safety Information on page 4 and accompanying full Prescribing Information and Medication Guide for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis, also available on www.ULTOMIRIS.com.

Please see Indications & Important Safety Information on page 5 and accompanying full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

VACCINATION ORDER FORM

EMAIL: OneSource@Alexion.com
PHONE: 1.888.765.4747 8:30 AM to 8 PM ET Monday-Friday
FAX: 1.800.420.5150
MAIL: 100 College St., New Haven, CT 06510

ONESOURCE®
Personalized Patient Support from Alexion

MENINGOCOCCAL VACCINATION SERIES PRESCRIBER ORDER FORM

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)			PATIENT DATE OF BIRTH (MM/DD/YYYY)
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER		HEIGHT	WEIGHT

CLINICAL INFORMATION

Primary Diagnosis Description: Encounter for Immunization | **ICD-10 CODE:** Z23

MENINGOCOCCAL VACCINATIONS ARE INDICATED FOR ADULTS, INCLUDING PEOPLE OVER 55 YEARS OF AGE, WHEN ON A COMPLEMENT INHIBITOR TREATMENT.

The Advisory Committee on Immunization Practices (ACIP) recommends a regimen of MenACWY and MenB doses prior to starting a complement inhibitor treatment. Vaccines should be initiated at least 2 weeks prior to administering the first dose of an Alexion complement inhibitor. There are two (2) types of meningococcal vaccines available in the United States, with different dosing schedules.

MenACWY — ONE (1) REQUIRED FROM EACH GROUP — MenB

MenB VACCINES ARE NOT INTERCHANGEABLE. PATIENT MUST RECEIVE THE SAME PRODUCT FOR ALL DOSES DURING A VACCINATION SERIES. FOR THE FULL VACCINE SCHEDULE, INCLUDING THE VACCINATION SCHEDULE FOR CHILDREN ≤10 YEARS OLD, PLEASE REFER TO THE ACIP VACCINE RECOMMENDATIONS OR TO ALEXION MEDICAL INFORMATION.

Three quadrivalent meningococcal conjugate (MenACWY) vaccines are currently licensed and available in the United States.

INDICATE VACCINE THE PATIENT NEEDS TO RECEIVE:

- ☐ Menveo (meningococcal groups A, C, W, and Y oligosaccharide diphtheria CRM conjugate vaccine [MenACWY-CRM]) 907340
- ☐ MenQuadfi (meningococcal groups A, C, W, and Y polysaccharide tetanus toxoid conjugate vaccine [MenACWY-TT]) 90619

Two serogroup B meningococcal (MenB) vaccines are currently licensed and available in the United States.

INDICATE VACCINE THE PATIENT NEEDS TO RECEIVE:

- ☐ Bexsero (MenB-4C) 90620
- ☐ Trumenba (MenB-FHbp) 90621

DOSING SCHEDULE

MenACWY

- ☐ Dose 1: Day 0
- ☐ Dose 2: At least 8 weeks after Day 0

MenB

- ☐ Dose 1: Day 0
- ☐ Dose 2: For Bexsero: At least (or greater than or equal to) 1 month after Day 0
  For Trumenba: 1-2 months after Day 0
- ☐ Dose 3 (*Trumenba only*): 6 months after Day 0

NOTE: ALL VACCINES LISTED ABOVE ARE ADMINISTERED INTRAMUSCULARLY AT A DOSE OF 0.5 mL

ANCILLARY ORDERS (HOME ADMINISTRATION ONLY - USE AS NEEDED)

Anaphylaxis Kit

The following items will be dispensed:

- ☑ Diphenhydramine 50 mg/mL 1 mL vial x 1. Inject 25 mg IM PRN for allergic reaction. May repeat x 1 dose in 15 min PRN if no improvement
- ☑ NS 500 mL bag x 1. Infuse 500 mL IV at KVO rate PRN anaphylaxis
- ☑ Epinephrine ampule/vial 1 mg/mL (1:1000) 1 mL x 2 ampules/vials. Inject 0.3 mg SQ PRN for adverse reaction. May repeat x 1 dose in 5 to 15 min PRN

General Anaphylaxis Instructions

Administer emergency medications as ordered. Administer epinephrine as above and repeat dose if necessary. Administer injectable diphenhydramine as above and repeat dose if necessary. Place peripheral IV and administer NS. Initiate CPR if needed. Call EMS (activate the emergency medical system). Monitor vital signs—elevate legs if hypotensive. Notify prescriber and Nursing Director or pharmacist.

PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) based on my clinical judgment, the vaccines identified are medically necessary for the patient and diagnosis identified on this form; (ii) I am authorized under applicable law to prescribe the vaccines identified and I have verified and complied with all applicable prescription requirements; (iii) I am authorizing Alexion to forward the patient's prescription(s) to a pharmacy; (iv) I am under no obligation to prescribe the vaccines identified and I have not received, nor will I receive, any benefit from Alexion; and (v) the information provided on this form is complete, current, and accurate to the best of my knowledge.

SIGN ONE

PRESCRIBER'S SIGNATURE (NO STAMPS) - **DISPENSE AS WRITTEN** DATE (MM/DD/YYYY)

PRESCRIBER'S SIGNATURE (NO STAMPS) - **MAY SUBSTITUTE** DATE (MM/DD/YYYY)

Please verify your local prescribing requirements (eg, New York prescribers must provide a separate prescription)

This material is intended only for residents of the United States.

INDICATION & IMPORTANT SAFETY INFORMATION FOR ULTOMIRIS® (ravulizumab-cwvz)

INDICATION

What is ULTOMIRIS?
ULTOMIRIS is a prescription medicine used to treat adults with a disease called generalized Myasthenia Gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive.

It is not known if ULTOMIRIS is safe and effective for the treatment of gMG in children.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about ULTOMIRIS?

ULTOMIRIS is a medicine that affects your immune system and can lower the ability of your immune system to fight infections.

- ULTOMIRIS increases your chance of getting serious and life-threatening meningococcal infections that may quickly become life-threatening and cause death if not recognized and treated early.

1. You must receive meningococcal vaccines at least 2 weeks before your first dose of ULTOMIRIS if you are not vaccinated.
2. If your healthcare provider decided that urgent treatment with ULTOMIRIS is needed, you should receive meningococcal vaccination as soon as possible.
3. If you have not been vaccinated and ULTOMIRIS therapy must be initiated immediately, you should also receive 2 weeks of antibiotics with your vaccinations.
4. If you had a meningococcal vaccine in the past, you might need additional vaccination. Your healthcare provider will decide if you need additional vaccination.
5. Meningococcal vaccines reduce but do not prevent all meningococcal infections. Call your healthcare provider or get emergency medical care right away if you get any of these signs and symptoms of a meningococcal infection: headache with nausea or vomiting, headache and fever, headache with a stiff neck or stiff back, fever, fever and a rash, confusion, muscle aches with flu-like symptoms and eyes sensitive to light.

Your healthcare provider will give you a Patient Safety Card about the risk of meningococcal infection. Carry it with you at all times during treatment and for 8 months after your last ULTOMIRIS dose. It is important to show this card to any healthcare provider or nurse to help them diagnose and treat you quickly.

ULTOMIRIS is only available through a program called the ULTOMIRIS REMS. Before you can receive ULTOMIRIS, your healthcare provider must: enroll in the ULTOMIRIS REMS program; counsel you about the risk of meningococcal infection; give you information and a **Patient Safety Card** about the symptoms and your risk of meningococcal infection (as discussed above); and make sure that you are vaccinated with a meningococcal vaccine, and if needed, get revaccinated with the meningococcal vaccine. Ask your healthcare provider if you are not sure if you need to be revaccinated.

ULTOMIRIS may also increase the risk of other types of serious infections. Call your healthcare provider right away if you have any new signs or symptoms of infection.

Who should not receive ULTOMIRIS?
Do not receive ULTOMIRIS if you have a meningococcal infection or have not been vaccinated against meningococcal infection unless your healthcare provider decides that urgent treatment with ULTOMIRIS is needed.

Before you receive ULTOMIRIS, tell your healthcare provider about all of your medical conditions, including if you: have an infection or fever, are pregnant or plan to become pregnant, and are breastfeeding or plan to breastfeed. It is not known if ULTOMIRIS will harm your unborn baby or if it passes into your breast milk. You should not breastfeed during treatment and for 8 months after your final dose of ULTOMIRIS.

Tell your healthcare provider about all the vaccines you receive and medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements which could affect your treatment.

What are the possible side effects of ULTOMIRIS?
ULTOMIRIS can cause serious side effects including infusion-related reactions. Symptoms of an infusion-related reaction with ULTOMIRIS may include lower back pain, tiredness, feeling faint, discomfort in your arms or legs, bad taste, or drowsiness. Stop treatment of ULTOMIRIS and tell your healthcare provider or nurse. Tell your healthcare provider or nurse right away if you develop these symptoms, or any other symptoms during your ULTOMIRIS infusion that may mean you are having a serious infusion reaction, including: chest pain, trouble breathing or shortness of breath, swelling of your face, tongue, or throat, and feel faint or pass out.

The most common side effects of ULTOMIRIS in people with gMG are diarrhea and upper respiratory tract infections.

Tell your healthcare provider about any side effect that bothers you or that does not go away. These are not all the possible side effects of ULTOMIRIS. For more information, ask your healthcare provider or pharmacist. Call your healthcare provider right away if you miss an ULTOMIRIS infusion or for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Please see the accompanying full Prescribing Information and Medication Guide for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis, also available on www.ULTOMIRIS.com.

INDICATION & IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab)

INDICATION

What is SOLIRIS?
SOLIRIS is a prescription medicine used to treat adults with a disease called generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about SOLIRIS?

SOLIRIS is a medicine that affects your immune system and can lower the ability of your immune system to fight infections.

- **SOLIRIS increases your chance of getting serious and life-threatening meningococcal infections that may quickly become life-threatening and cause death if not recognized and treated early.**

1. You must receive meningococcal vaccines at least 2 weeks before your first dose of SOLIRIS if you are not vaccinated.
2. If your doctor decided that urgent treatment with SOLIRIS is needed, you should receive meningococcal vaccination as soon as possible.
3. If you have not been vaccinated and SOLIRIS therapy must be initiated immediately, you should also receive two weeks of antibiotics with your vaccinations.
4. If you had a meningococcal vaccine in the past, you might need additional vaccination. Your doctor will decide if you need additional vaccination.
5. Meningococcal vaccines reduce but do not prevent all meningococcal infections. Call your doctor or get emergency medical care right away if you get any of these signs and symptoms of a meningococcal infection: headache with nausea or vomiting, headache and fever, headache with a stiff neck or stiff back, fever, fever and a rash, confusion, muscle aches with flu-like symptoms, and eyes sensitive to light.

Your doctor will give you a Patient Safety Card about the risk of meningococcal infection. Carry it with you at all times during treatment and for 3 months after your last SOLIRIS dose. It is important to show this card to any doctor or nurse to help them diagnose and treat you quickly.

SOLIRIS is only available through a program called the SOLIRIS REMS. Before you can receive SOLIRIS, your doctor must enroll in the SOLIRIS REMS program; counsel you about the risk of meningococcal infection; give you information and a **Patient Safety Card** about the symptoms and your risk of meningococcal infection (as discussed above); and make sure that you are vaccinated with the meningococcal vaccine and, if needed, get revaccinated with the meningococcal vaccine. Ask your doctor if you are not sure if you need to be revaccinated.

SOLIRIS may also increase the risk of other types of serious infections. Certain people may be at risk of serious infections with gonorrhea. Certain fungal infections *(Aspergillus)* may occur if you take SOLIRIS and have a weak immune system or a low white blood cell count.

Who should not receive SOLIRIS?
Do not receive SOLIRIS if you have a meningococcal infection or have not been vaccinated against meningitis infection unless your doctor decides that urgent treatment with SOLIRIS is needed.

Before you receive SOLIRIS, tell your doctor about all of your medical conditions, including if you: have an infection or fever, are pregnant or plan to become pregnant, and are breastfeeding or plan to breastfeed. It is not known if SOLIRIS will harm your unborn baby or if it passes into your breast milk.

Tell your doctor about all the vaccines you receive and medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements which could affect your treatment. It is important that you have all recommended vaccinations before you start SOLIRIS, receive 2 weeks of antibiotics if you immediately start SOLIRIS, and stay up-to-date with all recommended vaccinations during treatment with SOLIRIS.

What are the possible side effects of SOLIRIS?
SOLIRIS can cause serious side effects including serious infusion-related reactions. Tell your doctor or nurse right away if you get any of these symptoms during your SOLIRIS infusion: chest pain, trouble breathing or shortness of breath, swelling of your face, tongue, or throat, and feel faint or pass out. If you have an infusion-related reaction to SOLIRIS, your doctor may need to infuse SOLIRIS more slowly, or stop SOLIRIS.

The most common side effects in people with gMG treated with SOLIRIS include: muscle and joint (musculoskeletal) pain.

Tell your doctor about any side effect that bothers you or that does not go away. These are not all the possible side effects of SOLIRIS. For more information, ask your doctor or pharmacist. Call your doctor for medical advice about side effects. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit MedWatch, or call 1-800-FDA-1088.

Please see the accompanying full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

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PATIENT SERVICES ENROLLMENT FORM

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PHONE: 1.888.765.4747 8:30 AM to 8 PM ET Monday–Friday
FAX: 1.800.420.5150
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Personalized Patient Support from Alexion

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INSTRUCTIONS FOR PATIENTS

To enroll in OneSource, please follow these steps:

1. Complete all the required information (in red) on **this page** and read the Authorization to Share Health Information **on the next page**
2. Sign the Authorization to Share Health Information section on **this page**
3. Email or fax **this page** and **copies of the front and back of your insurance and pharmacy coverage cards** to OneSource (see the email address and fax number above)

Be sure to complete all required fields and sign and date the form. If information is incomplete, it could delay our ability to enroll you in OneSource. OneSource can start offering you personalized support once you submit this form fully and correctly completed.

Note: You can choose not to sign this form. However, we cannot provide personalized support without your signed authorization.

Contact OneSource if you have any questions while completing the forms.

Fields in red with asterisks are required.*

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)* | DATE OF BIRTH (MM/DD/YYYY)* | GENDER: ☐ MALE ☐ FEMALE ☐ NON-BINARY PREFER TO SELF-DESCRIBE:

ADDRESS*

CITY* | STATE* | ZIP*

PRIMARY PHONE NUMBER* ☐ MOBILE ☐ HOME | OK TO SEND A TEXT MESSAGE? ☐ YES ☐ NO | OK TO LEAVE A PHONE MESSAGE? ☐ YES ☐ NO

PATIENT DIAGNOSIS

PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____ | PATIENT EMAIL ☐ NONE _____

LEGAL PATIENT REPRESENTATIVE* (REQUIRED IF PATIENT IS A MINOR) | RELATIONSHIP TO PATIENT | EMAIL

NAME: | PHONE:

DESIGNATED CARE PARTNER | RELATIONSHIP TO PATIENT | EMAIL

NAME: | PHONE:

PRESCRIBING PHYSICIAN'S INFORMATION

PROVIDER NAME | PROVIDER PHONE NUMBER | PROVIDER EMAIL

AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I acknowledge that I have read and agree to the Authorization to Share Health Information terms on the next page.

SIGN HERE

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE* | DATE (MM/DD/YYYY)*

CONSENT FOR COPAY PROGRAM (OPTIONAL)

By signing below, I acknowledge that I have read and agree to the Alexion OneSource™ CoPay Program eligibility terms on the next page.

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE | DATE (MM/DD/YYYY)

CONSENT FOR AUTOMATED TEXT COMMUNICATIONS (OPTIONAL)

By signing below, I give Alexion and companies working at Alexion's direction permission to use automated text (SMS) messages to provide patient support services and to provide information to me about Alexion products, services, programs, or other topics that Alexion thinks may interest me. I understand that (i) I am not required to consent to receiving text messages as a condition of any purchase of Alexion products or enrollment in these programs; (ii) my telecommunication services provider may charge me for any text messages that I receive from Alexion; and (iii) I may opt out of receiving automated text messages from Alexion at any time without affecting my enrollment in these programs.

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE | DATE (MM/DD/YYYY)

AUTHORIZATION TO SHARE HEALTH INFORMATION

Alexion Pharmaceuticals, Inc. ("Alexion") offers patient services that include (but are not limited to) educational resources, case management support, and financial assistance for eligible patients.

By signing the prior page, I give permission for my healthcare providers, health plans, other insurance programs, pharmacies, and other healthcare service providers ("My Healthcare Entities") to share information, including protected health information relating to my medical condition, treatment, and health insurance coverage (collectively "My Information") with Alexion and companies working at its direction so that Alexion may use and disclose My Information to:

- review my eligibility for benefits for treatment with an Alexion product;
- coordinate treatment with an Alexion product, as well as related services, such as arranging home infusion services or vaccine services;
- access my credit information and information from other sources to estimate my income, if needed, to assess eligibility for financial assistance programs;
- remove identifiers from My Information and combine such resulting information with other information for research, regulatory submissions, business improvement projects, and publication purposes; and
- contact me about market research or clinical studies, provide me with educational and promotional materials, or otherwise contact me about Alexion products, services, programs, or other topics that Alexion thinks may interest me.

I understand that My Healthcare Entities may receive payment from Alexion in exchange for sharing My Information.

I understand that My Information is also subject to the Alexion Privacy Notice available at https://alexion.com/Legal#privacy, and that the Alexion Privacy Notice provides additional information about Alexion's privacy practices and the rights that may be available to me. Although Alexion has implemented privacy and security controls designed to help protect My Information, I understand that once My Information has been disclosed to Alexion, the Health Insurance Portability and Affordability Act ("HIPAA") may not apply and may no longer protect the information.

I understand that I may refuse to sign this Authorization and that My Healthcare Entities may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I also understand that if I do not sign this Authorization, I will not be able to receive support through the Alexion OneSource™ Patient Support Program.

This Authorization expires ten (10) years from the date next to my signature, unless I cancel/revoke it sooner, or unless a shorter time frame is required by applicable law.

I understand that I may revoke my Authorization, or unsubscribe or modify the services I receive, at any time by mailing a letter to Alexion OneSource Patient Support Program, 121 Seaport Blvd, Boston, MA 02210 or by emailing OneSource@Alexion.com. I also understand that revoking or modifying my authorization will not affect any use or disclosure of My Information that occurred before Alexion received notice of my cancellation. I also understand I have a right to receive a copy of this Authorization after it is signed and can request a copy at any time by contacting OneSource at 1.888.765.4747.

OneSource™ Services

Alexion services and support are subject to change. Participation is voluntary, and person(s) may be removed from Alexion services for code of conduct violations.

CoPay Program Eligibility

By participating in the Alexion OneSource CoPay Program, participants acknowledge that they understand and agree with the complete program terms and conditions available at https://alexiononesource.com/CoPay or on request by contacting OneSource at 1.888.765.4747.

This material is intended only for residents of the united States.

ONESOURCE®

Personalized Patient Support from Alexion

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ALEXION® AstraZeneca Rare Disease