PRESCRIBER FORM – PNH/ATYPICAL-HUS

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 form** and **copies of the front and back of the patient's medical 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

LEGAL PATIENT REPRESENTATIVE* (THIS SECTION IS REQUIRED IF PATIENT IS A MINOR)

NAME (FIRST, LAST)	PHONE NUMBER	RELATIONSHIP TO PATIENT	EMAIL

STEP 2: CLINICAL DIAGNOSIS

INDICATION (check one)*:

- ☐ PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) ICD-10: D59.5
- ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS) ICD-10:
  - ☐ D59.39 Other hemolytic-uremic syndrome
  - ☐ D59.32 Hereditary hemolytic-uremic syndrome
  - ☐ D59.30 Hemolytic-uremic syndrome, unspecified
  - ☐ D59.31 Infection-associated hemolytic-uremic syndrome, **excluding** Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)

STEP 3: INSURANCE INFORMATION

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

☐ COPIES OF PATIENT'S 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*	
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 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 3 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

US/ULT-P/0343 11/22

PRESCRIBER FORM – PNH/ATYPICAL-HUS

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ULTOMIRIS (ravulizumab-cwvz) SOLIRIS (eculizumab) ONESOURCE

Fields in red with asterisks are required.*

PATIENT INFORMATION

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

STEP 6: PRESCRIPTION (OPTIONAL) YOU MAY USE THIS SECTION TO PROVIDE A PRESCRIPTION FOR ULTOMIRIS OR SOLIRIS, OR YOU MAY PROVIDE A SEPARATE PRESCRIPTION.

A

☐ PLEASE PROVIDE SUMMARY OF BENEFIT INVESTIGATION FOR ULTOMIRIS AND SOLIRIS

PATIENT WEIGHT: _____

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

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

☐ **NO LOADING DOSE, PATIENT IS ON THERAPY**

MAINTENANCE DOSE:

SIG: INFUSE INTRAVENOUSLY _____ mg EVERY _____ WEEKS. START 2 WEEKS AFTER COMPLETION OF LOADING DOSE.

☐ OTHER: _____

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 FIFTH WEEK.

☐ OTHER: _____

QTY OF 300 mg/30 mL
VIALS: _____ REFILLS: 0

☐ **NO LOADING DOSE, PATIENT IS ON THERAPY**

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: _____

B

☐ I WOULD LIKE TO TRANSITION MY PATIENT FROM SOLIRIS TO ULTOMIRIS

ANTICIPATED ULTOMIRIS START DATE: _____

☐ PLEASE PROVIDE SUMMARY OF BENEFIT INVESTIGATION FOR ULTOMIRIS

PATIENT WEIGHT: _____

☐ **ULTOMIRIS** 100 mg/mL HCPCS CODE: J1303 PER UNIT

☐ **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

☐ **NO LOADING DOSE, PATIENT IS ON THERAPY**

MAINTENANCE DOSE:

SIG: INFUSE INTRAVENOUSLY _____ mg EVERY _____ WEEKS. START 2 WEEKS AFTER COMPLETION OF LOADING DOSE.

☐ OTHER: _____

QTY OF 300 mg/3 mL VIALS: _____ REFILLS: _____

QTY OF 1100 mg/11 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, start date: ___/___/___

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

MenACWY

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

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

MenB

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

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

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

✓ **Sign prescriber certification below**

NO

☐ Patient needs **VACCINATION SUPPORT** from OneSource

✓ **Sign prescriber certification below**

*The current ACIP guidelines recommend a regimen of MenACWY AND MenB doses prior to starting a complement inhibitor treatment.

STEP 7: 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 by any means under applicable law; and (iv) 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 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 3 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

INDICATIONS & IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab)

INDICATIONS

What is SOLIRIS?

SOLIRIS is a prescription medicine used to treat:

- patients with a disease called Paroxysmal Nocturnal Hemoglobinuria (PNH).
- adults and children with a disease called atypical Hemolytic Uremic Syndrome (aHUS). SOLIRIS is not for use in treating people with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

It is not known if SOLIRIS is safe and effective in children with PNH.

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. Make sure your child receives vaccinations against *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib) if treated with SOLIRIS. 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.

If you have PNH, your doctor will need to monitor you closely for at least 8 weeks after stopping SOLIRIS. Stopping treatment with SOLIRIS may cause breakdown of your red blood cells due to PNH. Symptoms or problems that can happen due to red blood cell breakdown include: drop in the number of your red blood cell count, drop in your platelet count, confusion, kidney problems, blood clots, difficulty breathing, and chest pain.

If you have aHUS, your doctor will need to monitor you closely during and for at least 12 weeks after stopping treatment for signs of worsening aHUS symptoms or problems related to abnormal clotting (thrombotic microangiopathy). Symptoms or problems that can happen with abnormal clotting may include: stroke, confusion, seizure, chest pain (angina), difficulty breathing, kidney problems, swelling in arms or legs, and a drop in your platelet count.

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 PNH treated with SOLIRIS include: headache, pain or swelling of your nose or throat (nasopharyngitis), back pain, and nausea.

The most common side effects in people with aHUS treated with SOLIRIS include: headache, diarrhea, high blood pressure (hypertension), common cold (upper respiratory infection), stomach-area (abdominal) pain, vomiting, pain or swelling of your nose or throat (nasopharyngitis), low red blood cell count (anemia), cough, swelling of legs or feet (peripheral edema), nausea, urinary tract infections, and fever.

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 full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections.

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

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

INDICATIONS

What is ULTOMIRIS?

ULTOMIRIS is a prescription medicine used to treat:

- adults and children 1 month of age and older with a disease called Paroxysmal Nocturnal Hemoglobinuria (PNH).
- adults and children 1 month of age and older with a disease called atypical Hemolytic Uremic Syndrome (aHUS). ULTOMIRIS is not used in treating people with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

It is not known if ULTOMIRIS is safe and effective in children younger than 1 month of age.

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. Make sure your child receives vaccinations against *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib) if treated with ULTOMIRIS. 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.

If you have PNH and you stop receiving ULTOMIRIS, your healthcare provider will need to monitor you closely for at least 16 weeks after you stop ULTOMIRIS. Stopping ULTOMIRIS may cause breakdown of your red blood cells due to PNH. Symptoms or problems that can happen due to red blood cell breakdown include: drop in your red blood cell count, tiredness, blood in your urine, stomach-area (abdomen) pain, shortness of breath, blood clots, trouble swallowing, and erectile dysfunction (ED) in males.

If you have aHUS, your healthcare provider will need to monitor you closely for at least 12 months after stopping treatment for signs of worsening aHUS or problems related to a type of abnormal clotting and breakdown of your red blood cells called thrombotic microangiopathy (TMA). Symptoms or problems that can happen with TMA may include: confusion or loss of consciousness, seizures, chest pain (angina), difficulty breathing and blood clots or stroke.

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 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 treated for PNH are upper respiratory tract infection and headache.

The most common side effects of ULTOMIRIS in people treated for aHUS are upper respiratory tract infection, diarrhea, nausea, vomiting, headache, high blood pressure and fever.

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 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.

PATIENT SERVICES ENROLLMENT FORM

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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 medical 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.

Fields in red with asterisks are required.* **Contact OneSource if you have any questions while completing the form.**

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 A PATIENT IS A MINOR)
NAME: PHONE: RELATIONSHIP TO PATIENT EMAIL

DESIGNATED CARE PARTNER
NAME: PHONE: RELATIONSHIP TO PATIENT EMAIL

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 terms and conditions available at https://alexiononesource.com/CoPay or on request by contacting OneSource at 1.888.765.4747.

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 including 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, 100 College Street, New Haven, CT 06510 or by emailing OneSource@Alexion.com. I also understand that 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.

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