PATIENT START FORM – NEUROLOGY

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

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial | ONESOURCE™ Personalized Patient Support from Alexion

Steps to enroll in patient support programs:

1. Fill out the **PATIENT INFORMATION** section below.
2. Read the "Authorization to Share Health Information" agreement on **PAGE 2 and sign below**.
3. Once complete, this form should be emailed or faxed with copies of your medical insurance and pharmacy coverage cards.

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)		
DATE OF BIRTH (MM/DD/YYYY)	ADDRESS	
CITY	STATE	ZIP
PREFERRED PHONE NUMBER ( )	BEST TIME TO CONTACT ☐ MORNING ☐ AFTERNOON ☐ EVENING	PREFERRED LANGUAGE
OK TO LEAVE A PHONE MESSAGE? ☐ YES ☐ NO OK TO SEND A TEXT MESSAGE? ☐ YES ☐ NO	EMAIL	
LEGALLY AUTHORIZED REPRESENTATIVE (OPTIONAL) NAME:	RELATIONSHIP TO PATIENT:	
PHONE NUMBER ( )	EMAIL	
OTHER PERSON WITH WHOM WE CAN SHARE YOUR HEALTH INFORMATION NAME:	RELATIONSHIP TO PATIENT:	
PHONE NUMBER ( )	EMAIL	

PRESCRIBING PHYSICIAN'S INFORMATION

PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S PHONE NUMBER ( )

AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, YOU ACKNOWLEDGE THAT YOU HAVE READ AND AGREE WITH THE AUTHORIZATION TO SHARE HEALTH INFORMATION ON PAGE 2 and consent to the terms, including that you authorize the release of your information by healthcare providers and payers, which includes health insurance companies.

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

CONSENT FOR MAIL AND EMAIL PROMOTIONAL COMMUNICATIONS (OPTIONAL)

☐ By checking this box, I give Alexion permission to use my contact information to provide promotional information to me about Alexion products, services, programs, or other topics that Alexion thinks may interest me. Alexion agrees to use my information per their privacy notice (available at https://alexion.com/Legal#privacy) and will not sell my information.

CONSENT FOR PHONE AND TEXT PROMOTIONAL COMMUNICATIONS (OPTIONAL)

☐ By checking this box, you authorize Alexion and its service providers to use auto-dialers and/or prerecorded or artificial voice to contact you at the telephone numbers you provide above with promotional or other marketing messages. You understand that these calls/texts may mention the names of Alexion products or services. You understand that you are not required to consent to being contacted for promotional or marketing purposes by phone or text message as a condition of any purchase of Alexion products or as a condition of enrollment in OneSource. You understand that you may be charged for these calls and/or text messages by your telecommunication services provider and that the frequency of these calls or text messages will vary. You understand that you may opt out of receiving these communications at any time by calling 1.888.765.4747.

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

Please see Indications & Important Safety Information on page 6 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/SOL-g/0289 03/21

AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing, I understand that Alexion Pharmaceuticals, Inc. offers patient services from OneSource which include, but are not limited to: educational resources, case management support, and financial assistance for eligible patients.

By signing below, I give my permission for my healthcare providers, health plans, and pharmacies ("My Healthcare Entities") to share with Alexion Pharmaceuticals, Inc., its present and future affiliates, vendors and other companies working with and on behalf of Alexion Pharmaceuticals, Inc. (collectively, "Alexion"), personal information relating to my medical condition, treatment, and health insurance coverage ("My Information") so that Alexion may: 1) obtain information on insurance coverage for my treatment; 2) review my eligibility for benefits from my health plan or other programs for my treatment; 3) coordinate treatment care with My Healthcare Entities; 4) facilitate my access to OneSource programs; 5) access my credit information and information derived from public and other sources to estimate my income as part of the determination of eligibility for financial assistance; 6) remove identifiers from My Information, or combine My Information with the information of others who participate in OneSource to create aggregated data, and use such data for analytics, research, business improvement projects, and publication purposes; and 7) contact me for non-promotional purposes, such as market research, safety updates, and Alexion-sponsored clinical research studies.

I understand that my enrollment in OneSource is also subject to the Alexion Privacy Notice, available at https://alexion.com/Legal#privacy, which provides me with additional information about Alexion's privacy practices and the rights that may be available to me.

I understand that, once My Information has been disclosed to Alexion, federal privacy law may no longer protect the information. I also understand, however, that Alexion intends to protect My Information by using and disclosing it only for purposes authorized in this Authorization, the Alexion Privacy Notice, or as required by law.

I understand that my pharmacy and health insurers may receive remuneration (payment) from Alexion in exchange for sharing My Information with Alexion to facilitate the patient support programs and other purposes described in this Authorization which are related to my potential treatment with an Alexion therapy.

I understand that I may refuse to sign this Authorization, and that refusing will not affect my treatment, insurance enrollment, or eligibility for insurance benefits, but it will make me ineligible to participate in those OneSource patient support programs requiring such an authorization, including its financial assistance program. If I do sign, I may cancel this authorization at any time by mailing a letter to Alexion, 121 Seaport Blvd Boston, MA 02210 or emailing OneSource@Alexion.com. I understand that canceling this Authorization will not invalidate reliance on this Authorization to use or disclose My Information prior to Alexion's receipt of my notice of cancellation.

This Authorization expires ten (10) years from the date next to my signature, unless I revoke it sooner, or unless a shorter time frame is required by applicable law. I understand I have a right to receive a copy of this Authorization after it is signed.

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PRESCRIBER START FORM – NEUROLOGY

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ONESOURCE™ Personalized Patient Support from Alexion

Product: SOLIRIS® (eculizumab)
NDC # 25682-0001-01/HCPCS Code: J1300 per unit
ICD-10 MG (G70.00)/NMOSD (G36.0)

1. **The prescriber should fill out PAGES 3, 4, and 5.**
2. **The prescriber should fax or email** completed **PAGES 3, 4, and 5** along with completed patient **PAGE 1** and copies of patient cards.

Prescriber's signature is required in order to fill a SOLIRIS prescription.

STEP 1: PATIENT INFORMATION AND DIAGNOSIS

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	
DATE OF BIRTH (MM/DD/YYYY)	SEX: ☐ MALE ☐ FEMALE
DIAGNOSIS: ☐ gMG ☐ NMOSD	ANTIBODY STATUS: ☐ ANTI-AChR ANTIBODY POSITIVE (gMG) ☐ ANTI-AQP4 ANTIBODY POSITIVE (NMOSD)
DATE OF DIAGNOSIS: (MM/DD/YYYY)	

STEP 2: CLINICAL INFORMATION

CHECK ALL PREVIOUS GENERALIZED MYASTHENIA GRAVIS (GMG) THERAPIES:

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

CHECK ALL PREVIOUS NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD) THERAPIES:

☐ AZATHIOPRINE ☐ MITOXANTRONE ☐ RITUXIMAB
☐ CYCLOPHOSPHAMIDE ☐ MYCOPHENOLATE MOFETIL ☐ SATRALIZUMAB
☐ METHOTREXATE ☐ OTHER ☐ STEROID
☐ INEBILIZUMAB

MGFA CLASSIFICATION:	NUMBER OF RELAPSES IN LAST 12 MONTHS: 24 MONTHS:
CURRENT MG-ADL SCORE:	EDSS SCORE:

Abbreviations: AChR, acetylcholine receptor; EDSS, Expanded Disability Status Scale; gMG, generalized myasthenia gravis; IVIg, intravenous immunoglobulin; MG-ADL, Myasthenia Gravis Activities of Daily Living; MGFA, Myasthenia Gravis Foundation of America; NMOSD, neuromyelitis optica spectrum disorder.

STEP 3: HEALTHCARE PRESCRIBER INFORMATION

FIRST NAME	LAST NAME	CREDENTIALS
PRACTICE NAME		PHONE NUMBER ( )
ADDRESS		
CITY	STATE	ZIP
NPI #	TAX ID #	EMAIL
OFFICE CONTACT	PHONE NUMBER ( )	FAX NUMBER ( )

STEP 4: SITE OF CARE INFORMATION

☐ I NEED HELP FINDING A SITE OF CARE CENTER FOR MY PATIENT ☐ CONTACT MY PATIENT DIRECTLY FOR SITE OF CARE SUPPORT

IF YOU DO NOT NEED SUPPORT, PLEASE COMPLETE THE REMAINDER OF STEP 4 BELOW.

MY PATIENT'S SITE OF CARE LOCATION: ☐ PRESCRIBER'S OFFICE ☐ AT HOME ☐ INPATIENT ☐ OUTPATIENT OFF CAMPUS ☐ OUTPATIENT ON CAMPUS

SITE OF CARE NAME	SITE OF CARE TAX ID #	SITE OF CARE NPI #
ADDRESS		
CITY	STATE	ZIP
OFFICE CONTACT FOR FOLLOW-UP	SHIP PRODUCT TO: ☐ HEALTHCARE PRESCRIBER'S OFFICE ☐ SITE OF CARE ABOVE ☐ THIS ADDRESS:	

STEP 5: INSURANCE INFORMATION *(REMEMBER TO SEND IN COPIES OF THE FRONT AND BACK OF YOUR PATIENT'S INSURANCE CARD, AND THEIR PHARMACY COVERAGE CARD, ALONG WITH THIS FORM.)*

BILLING SITE FOR CLAIM: ☐ HCP ☐ SITE OF CARE

PRIMARY INSURANCE NAME		SECONDARY INSURANCE HOLDER	
POLICYHOLDER NAME		POLICYHOLDER NAME	
PHONE NUMBER ( )	POLICYHOLDER DOB (MM/DD/YYYY)	PHONE NUMBER ( )	POLICYHOLDER DOB (MM/DD/YYYY)
POLICY ID #	GROUP #	POLICY ID #	GROUP #

Please see Indications & Important Safety Information on page 6 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.

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PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	DATE OF BIRTH (MM/DD/YYYY)
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S PHONE NUMBER ( )

STEP 6: PHARMACY COVERAGE *(REMEMBER TO SEND IN COPIES OF THE FRONT AND BACK OF YOUR PATIENT'S INSURANCE CARD, AND THEIR PHARMACY COVERAGE CARD, ALONG WITH THIS FORM.)*

PRESCRIPTION INSURANCE	POLICY ID #
INSURANCE PHONE NUMBER ( )	RX GROUP #
RX BIN #	RX PCN #

STEP 7: VACCINATION INFORMATION AND SUPPORT

SELECT THE STATUS OF YOUR PATIENT'S VACCINATION

A ☐ PATIENT IS ALREADY SCHEDULED FOR VACCINATIONS BY A HEALTHCARE PROVIDER

B ☐ PATIENT HAS RECEIVED VACCINATIONS **(CHECK ALL MENINGOCOCCAL VACCINATIONS RECEIVED BELOW)**:

MenACWY (AT LEAST 1 DOSE) ☐ Menveo® OR ☐ Menactra® OR ☐ MenQuadfi®

DATE OF FIRST DOSE RECEIVED (MM/DD/YYYY): _____ DATE OF SECOND DOSE RECEIVED: (MM/DD/YYYY): _____

MenB (AT LEAST 1 DOSE) ☐ Bexsero® OR ☐ Trumenba® (3 DOSES REQUIRED)

DATE OF FIRST DOSE RECEIVED (MM/DD/YYYY): _____ DATE OF SECOND DOSE RECEIVED: (MM/DD/YYYY): _____

DATE OF THIRD DOSE RECEIVED (MM/DD/YYYY): _____

C ☐ PATIENT NEEDS VACCINATION SUPPORT

PRIMARY DIAGNOSIS DESCRIPTION: ENCOUNTER FOR IMMUNIZATION **ICD-10 CODE:** Z23

(PLEASE INDICATE WHICH VACCINES THE PATIENT NEEDS TO RECEIVE AND AT WHAT TIME POINTS THE VACCINES SHOULD BE ADMINISTERED)

(NOTE: ALL VACCINES LISTED BELOW ARE ADMINISTERED INTRAMUSCULARLY AT A DOSE OF 0.5 mL)

MenACWY*

1ST DOSE: ON DAY 0	2ND DOSE: AT LEAST 8 WEEKS LATER
☐ MENVEO ☐ MENACTRA ☐ MENQUADFI	☐ MENVEO ☐ MENACTRA ☐ MENQUADFI

MenB** BEXSERO

1ST DOSE: ON DAY 0	2ND DOSE: AT LEAST 1 MONTH LATER
☐ 1ST DOSE	☐ 2ND DOSE

MenB**TRUMENBA

1ST DOSE: ON DAY 0	2ND DOSE: 1-2 MONTHS AFTER DOSE 1	3RD DOSE: 6 MONTHS AFTER DOSE 1[a]
☐ 1ST DOSE	☐ 2ND DOSE	☐ 3RD DOSE

[a]For Trumenba, if dose 2 was administered at least 6 months after dose 1, dose 3 is not needed.

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

1. Menactra (meningococcal groups A, C, W, and Y polysaccharide diphtheria toxoid conjugate vaccine (MenACWY-D));
2. Menveo (meningococcal groups A, C, W, and Y oligosaccharide diphtheria CRM conjugate vaccine (MenACWY-CRM));
3. MenQuadfi (meningococcal groups A, C, W, and Y polysaccharide tetanus toxoid conjugate vaccine (MenACWY-TT))

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

1. Bexsero (MenB-4C)
2. Trumenba (MenB-FHbp)

Vaccinations are indicated for adults, including people over 55 years of age, when on a complement inhibitor treatment.

CPT codes: 907340 - Menveo, Menactra; 90619 - MenQuadfi; 90620 - BEXSERO; 90621 - Trumenba; 90460 - vaccine administration

FOR THE FULL VACCINE SCHEDULE, PLEASE REFER TO THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) VACCINE RECOMMENDATIONS OR TO ALEXION MEDICAL INFORMATION.

Please see Indications & Important Safety Information on page 6 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.

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PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	DATE OF BIRTH (MM/DD/YYYY)
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S PHONE NUMBER ( )

STEP 8: SOLIRIS PRESCRIPTION ORDER AND PRESCRIBER SIGNATURE (OPTIONAL)

☐ SOLIRIS® (eculizumab) NDC # 25682-0001-01/HCPCS CODE: J1300 PER UNIT ICD-10 MG (G70.00)/NMOSD (G36.0)

WEEKS 1 THROUGH 4 (RECOMMENDED DOSE 900 MG WEEKLY FOR FIRST 4 WEEKS):

☐ _____ 300-MG SINGLE-DOSE SOLIRIS VIALS (12 RECOMMENDED)

☐ OTHER: DISPENSE _____ 300-MG SINGLE-DOSE SOLIRIS VIALS

INSTRUCTIONS:

WEEK 5 (RECOMMENDED DOSE 1200 MG 1 WEEK AFTER PREVIOUS DOSE):

☐ _____ 300-MG SINGLE-DOSE SOLIRIS VIALS (4 RECOMMENDED)

☐ OTHER: DISPENSE _____ 300-MG SINGLE-DOSE SOLIRIS VIALS

INSTRUCTIONS:

MAINTENANCE TREATMENT (RECOMMENDED DOSE 1200 MG EVERY 2 WEEKS):

☐ DISPENSE _____ 300-MG SINGLE-DOSE SOLIRIS VIALS

INSTRUCTIONS:

PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) based on my clinical judgment, SOLIRIS is medically necessary for the patient identified on this form for the indication noted on this form, and I will be supervising the patient's treatment; (ii) I am authorized under applicable law to prescribe and dispense SOLIRIS, and I authorize forwarding of this prescription to a pharmacy; (iii) I am under no obligation to prescribe SOLIRIS and I have not received, nor will I receive, any benefit from Alexion for prescribing SOLIRIS; and (iv) the information provided is complete, current, and accurate to the best of my knowledge. By signing below, I further certify that I have obtained the patient's authorization to release the information contained in this form and such other information as may be required by Alexion to enroll the patient in OneSource, and I authorize OneSource to contact me solely for the purpose of the patient support program. If I am a NJ or NY physician, I attest that I have attached a prescription that complies with applicable state laws. If I am a physician in all other states, I attest that I have verified and complied with all applicable prescription requirements.

SIGN HERE	PRESCRIBER SIGNATURE:	DATE (MM/DD/YYYY)

Please see Indications & Important Safety Information on page 6 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.

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INDICATIONS & IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab)

INDICATIONS
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.
- adults with a disease called neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive.

It is not known if SOLIRIS is safe and effective in children with gMG or NMOSD.

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.

The most common side effects in people with NMOSD treated with SOLIRIS include: common cold (upper respiratory infection), pain or swelling of your nose or throat (nasopharyngitis), diarrhea, back pain, dizziness, flu like symptoms (influenza) including fever, headache, tiredness, cough, sore throat, and body aches, joint pain (arthralgia), throat irritation (pharyngitis), and bruising (contusion).

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 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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ALEXION®

SOLIRIS PRESCRIBER START FORM – A HOW-TO GUIDE

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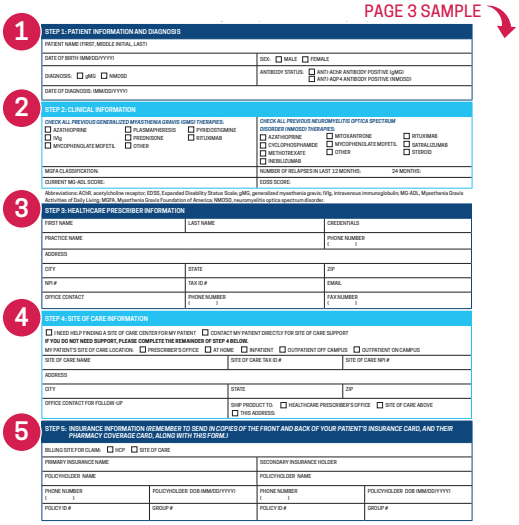
GENERAL INSTRUCTIONS

PRESCRIBER: Use these tips as guidelines to help complete the **PRESCRIBER START FORM**. By completing the form, you can initiate a prescription of SOLIRIS for your patients.

NOTE: Your patient also needs to sign PAGE 1 of the **PATIENT START FORM**. Upon completion, fax or email PAGES 1, 3, 4, AND 5 to OneSource, along with copies of the front and back of your patient's medical insurance and pharmacy coverage cards. The fax number and email address are listed above.

PAGE 3 SAMPLE



STEPS 1 & 2

Fill out relevant information about your patient and their diagnosis. Do your best to fill out these fields, especially the one related to antibody status.

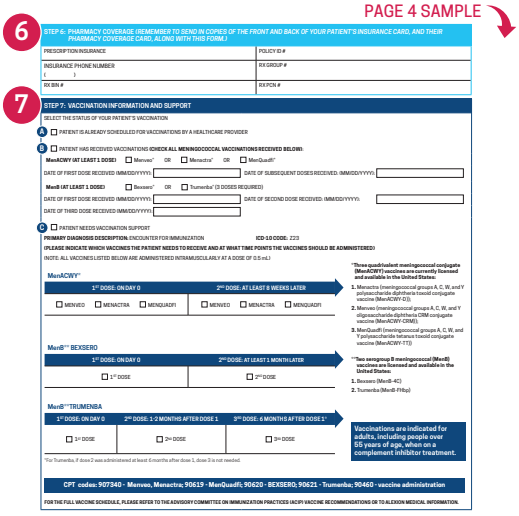
STEP 3

The information in this section is essential to complete as it requires prescriber details. Any delays in getting this information can prevent the start of treatment.

STEPS 4 & 5

Provide information about the planned site of care for your patient as well as the patient's insurance information.

PAGE 4 SAMPLE



STEP 6

Some patients have additional pharmacy benefits. If your patient has this type of coverage, please add those details here.

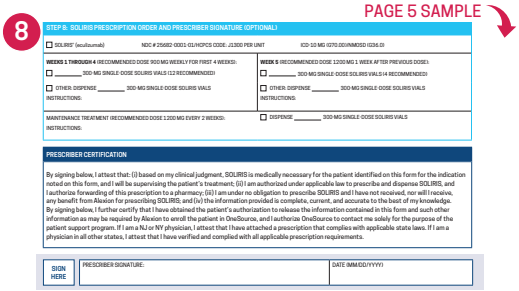
Remember to send in copies of the front and back of their insurance and pharmacy coverage cards with completed forms.

STEP 7

Choose one of the three support options offered to your patient. Depending on your selection and your patient's insurance coverage, OneSource will be able to assist your patient.

NOTE: **Option C** requires a prescription for the vaccination.

PAGE 5 SAMPLE



STEP 8

This optional step of the form is the SOLIRIS prescription. Your signature is required only if you are prescribing SOLIRIS. Remember to complete the fields you have information for, and sign and date the form.

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

Please return these four pages to OneSource (1 and 3-5) via fax or email.

FOR PATIENTS: TAKE THIS PAGE HOME TO REFER BACK TO WHEN NEEDED.

ONESOURCE: WE'RE HERE TO HELP.

WHAT YOU CAN EXPECT

Once we receive your PATIENT START FORM, OneSource will call you in 1-2 business days to discuss:

- Health Insurance Navigation
- Vaccination Support
- Infusion Location
- Additional support based on your questions

VISIT: alexiononesource.com **CALL:** 1.888.765.4747 **EMAIL:** OneSource@Alexion.com

ADD ONESOURCE TO YOUR CONTACTS:

Go to your camera on your mobile device

Scan the QR code on the left

This number, 1.888.765.4747, will be automatically added to your contact list so you'll recognize the caller.

OneSource is a complimentary, personalized patient support program offered by Alexion. It's designed to support your specific needs throughout treatment. When you fill out and sign the **PATIENT START FORM**, OneSource will reach out to help you get started.

Once you're enrolled, OneSource experts can support you with:

DISEASE INFORMATION
Educational materials and resources related to your diagnosis.

ONGOING SUPPORT
Support to help you follow the care plan from your physician.

HEALTH INSURANCE NAVIGATION
Options to help you access treatment, no matter your insurance coverage.

COMMUNITY CONNECTIONS
Information about patient meetings, events, and advocacy groups.

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