PRESCRIBER FORM - NF1 PN
(NF1, NEUROFIBROMATOSIS TYPE 1; PN, PLEXIFORM NEUROFIBROMA)

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

Koselugo (selumetinib) 10 mg & 25 mg capsules

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)*: ☐ SYMPTOMATIC INOPERABLE PN ASSOCIATED WITH NF1 ☐ OTHER - CONTACT ONESOURCE TO DETERMINE ELIGIBILITY

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

Please see Indication and Important Safety Information on page 3 and full Prescribing Information for Koselugo, available on Koselugo.com.

US/KOS-NF1/0433 12/22

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Fields in red with asterisks are required.*

PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)*

DATE OF BIRTH (MM/DD/YYYY)*

STEP 5: PRESCRIPTION

Koselugo is available via prescription either through a sole contracted specialty pharmacy (ONCO360) or through one of our authorized specialty distributors.

SPECIALTY PHARMACY PROVIDER (SPP)

☐ ONCO360 ☐ ON-SITE DISPENSE (prescription information does not need to be completed): _____ ☐ NO PREFERENCE†

ON-SITE DISPENSE PHONE NUMBER: _____

†*If you have questions about in-network SPP(s) for your patient, contact OneSource at 1.888.765.4747. If you choose "No Preference," the SPP will be chosen based on the results of a benefits investigation.*

KOSELUGO® (selumetinib)

25-mg CAPSULES QUANTITY: _____ REFILLS: _____

10-mg CAPSULES QUANTITY: _____ REFILLS: _____

DOSE INSTRUCTIONS: _____

HEIGHT & DATE: _____

WEIGHT & DATE: _____

FREE LIMITED SUPPLY (FLS) REQUEST

FREE LIMITED SUPPLY IS AVAILABLE FOR ELIGIBLE PATIENTS WHO FACE A DELAY IN APPROVAL BY THEIR INSURANCE COMPANY FOR KOSELUGO.

KOSELUGO® (selumetinib)

25-mg CAPSULES QUANTITY: _____

10-mg CAPSULES QUANTITY: _____

DOSE INSTRUCTIONS: _____

STEP 6: PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) based on my clinical judgment, Koselugo is medically necessary for the patient and diagnosis identified on this form and I will be supervising the patient's treatment; (ii) I am authorized under applicable law to prescribe Koselugo 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; (iv) I am under no obligation to prescribe Koselugo and I have not received, nor will I receive, any benefit from Alexion for prescribing Koselugo; 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 Indication and Important Safety Information on page 3 and full Prescribing Information for Koselugo, available on Koselugo.com.

US/KOS-NF1/0433 12/22

IMPORTANT SAFETY INFORMATION

Before taking Koselugo, tell your healthcare provider about all of your medical conditions, including if you:

- have heart problems
- have eye problems
- are pregnant or plan to become pregnant. Koselugo can harm your unborn baby
  - Females who could become pregnant and males with female partners who could become pregnant should use effective birth control (contraception) during treatment with Koselugo and for 1 week after your last dose
  - Tell your healthcare provider right away if you become pregnant or think you may be pregnant during treatment with Koselugo
- are breastfeeding or plan to breastfeed. It is not known if Koselugo passes into your breast milk
  - Do not breastfeed during treatment with Koselugo and for 1 week after your last dose
  - Talk to your healthcare provider about the best way to feed your baby during this time

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, or herbal supplements. Especially tell your healthcare provider if you are taking aspirin, blood thinners, or other medicines to treat blood clots. Koselugo contains vitamin E, which may increase your risk of bleeding.

Koselugo may cause serious side effects, including:

Heart problems. Koselugo can lower the amount of blood pumped by your heart, which is common and can also be severe. Your healthcare provider will do tests before and during treatment with Koselugo to check how well your heart is working. Tell your healthcare provider right away if you get any of the following signs or symptoms:

- persistent coughing or wheezing
- shortness of breath
- swelling of your ankles and feet
- tiredness
- increased heart rate

Eye problems. Koselugo can cause eye problems that can lead to blindness. Your healthcare provider will check your vision before and during treatment with Koselugo. Tell your healthcare provider right away if you get any of the following signs or symptoms:

- blurred vision
- loss of vision
- dark spots in your vision (floaters)
- other changes to your vision

Severe diarrhea. Diarrhea is common with Koselugo and can also be severe. Tell your healthcare provider right away the first time that you get diarrhea during treatment with Koselugo. Your healthcare provider may give you medicine to help control your diarrhea and may tell you to drink more fluids.

Skin rash. Skin rashes are common with Koselugo and can also be severe. Tell your healthcare provider if you get any of the following signs or symptoms:

- rash that covers a large area of your body
- peeling skin
- blisters

Muscle problems (rhabdomyolysis). Muscle problems are common with Koselugo and can also be severe. Treatment with Koselugo may increase the level of a muscle enzyme in your blood, which may be a sign of muscle damage. Your healthcare provider should do a blood test to check your muscle enzyme levels before you start taking Koselugo and during treatment. Tell your healthcare provider right away if you get any of the following signs or symptoms:

- muscle aches or pain
- muscle spasms and weakness
- dark, reddish urine

Your healthcare provider may change your dose, temporarily stop, or permanently ask you to stop taking Koselugo if you have any of these side effects.

The most common side effects of Koselugo are:

- vomiting
- stomach pain
- nausea
- dry skin
- feeling of tiredness, weakness, or lacking energy
- muscle and bone pain
- fever
- inflammation of the mouth
- headache
- redness around the fingernails
- itching

These are not all the possible side effects of Koselugo.

INDICATION

What is Koselugo?

Koselugo is a prescription medicine that is used to treat children 2 years of age and older with neurofibromatosis type 1 (NF1) who have plexiform neurofibromas that cannot be completely removed by surgery.

It is not known if Koselugo is safe and effective in children under 2 years of age.

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

PATIENT SERVICES ENROLLMENT FORM

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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 eligibility terms and conditions available at https://alexiononesource.com/KOSCoPay 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.