INSTRUCTIONS FOR PRESCRIBERS

TO START THE ONESOURCE™ ENROLLMENT PROCESS FOR YOUR PATIENT:

- ✓ Ask your patient to complete the **PATIENT FORM**
- ✓ Follow the below steps to complete this **PRESCRIBER FORM**
- ✓ Fax **ANY** completed forms to OneSource at **1-800-420-5150**

If vaccination support is needed, reach out to OneSource for the Vaccination Order Form

PAGE #1 INSTRUCTIONS

STEP #1
PROVIDE PATIENT INFORMATION

Please also provide legal patient representative information if applicable.

STEP #2
SELECT CLINICAL DIAGNOSIS

It is crucial to ensure that an indication is selected.

If not filled out, there may be delays in initiating treatment support for your patient.

STEP #3
PROVIDE INSURANCE INFORMATION

If you prefer, you can skip this and simply attach copies of the front and back of your patient's insurance cards.

It is important that we have information on BOTH medical and pharmacy benefits for your patient.

STEP #4
PROVIDE INFORMATION ABOUT YOURSELF

This information is critical when assisting with benefits investigation and financial programs.

STEP #5
INPUT SITE OF CARE INFORMATION

If you require assistance in locating an infusion site, check box "A."

If you know the site of care where the treatment will be provided, check box "B" and fill out the details below.

The site of care details will help when assisting with benefits investigation and financial programs.

PAGE #2 INSTRUCTIONS

STEP #6
COMPLETE PRESCRIPTION

You can simply prescribe through your usual prescription method, or you can use this prescription form.

Either way, your signature is still required on this form.

STEP #7
PROVIDE PATIENT VACCINATION HISTORY

After you complete this form, you will need to provide the patient vaccination history if you have not done so already.

You may also check the box if your patient needs comprehensive VACCINATION SUPPORT from OneSource.

STEP #8
SIGN THE PRESCRIBER CERTIFICATION

Your signature is required to attest that the information is complete, up-to-date, and accurate based on current knowledge.

Only one of the two signatures is required.

QUESTIONS ABOUT THE FORMS?

Contact OneSource at 1.888.765.4747

STEP 1: PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)*	DATE OF BIRTH (MM/DD/YYYY)*	PATIENT PHONE NUMBER*	PATIENT EMAIL
Jane Doe	10/10/1980	(555) 555-5555	emailname@email.com

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

NAME (FIRST, LAST)	PHONE NUMBER	RELATIONSHIP TO PATIENT	EMAIL
Justin Michaels	(555) 555-5555	Father	emailname@email.com

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).

☐ PLEASE PROVIDE SUMMARY OF BENEFIT INVESTIGATION FOR ULTOMIRIS AND SOLIRIS

☐ COPIES OF PATIENT'S INSURANCE CARD(S) ATTACHED
☐ PATIENT DOES NOT HAVE INSURANCE

	PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE	PHARMACY COVERAGE
INSURANCE PROVIDER	XYZ Company		ABC Company
INSURANCE PHONE #	(555) 555-5555		888-555-5555
CARDHOLDER NAME	Jane Doe		Jane Doe
CARDHOLDER DATE OF BIRTH	10/10/1980		10/10/1980
MEMBER ID	ABC12345D6789		12345D6789
POLICY #	12345678		12345678
GROUP #	1234567		1234567
BIN #			123456
PCN #			12345678910

STEP 4: HEALTHCARE PRESCRIBER INFORMATION

FIRST NAME*	LAST NAME*	PROVIDER EMAIL:*
Kenneth	Adams	emailname@email.com

ADDRESS*	PHONE NUMBER*
123 Sample Street	(555) 555-5555

CITY*	STATE*	ZIP*
New York	NY	01234

PRACTICE NAME	TAX ID #*	NPI #*
Central Health	10-987654	2019181716

OFFICE CONTACT NAME	EMAIL	FAX NUMBER
Catherine Green	emailname@email.com	(555) 555-5555

STEP 5: SITE OF CARE

SELECT OPTION A OR B BELOW:

☐ A) **PLEASE PROVIDE ASSISTANCE LOCATING AN INFUSION SITE.**

☑ B) **ASSISTANCE IS NOT NEEDED.** PATIENT WILL BE INFUSED AT: ☐ PRESCRIBER'S OFFICE ☑ INFUSION SITE (specify details below) ☐ HOME (specify specialty pharmacy below)

SITE OF CARE NAME	NPI #	TAX ID #
New York Infusion Center	0123456789	12-141312

ADDRESS: 123 Park Street

CITY	STATE	ZIP
New York	NY	01234

OFFICE CONTACT FOR FOLLOW-UP	PHONE NUMBER
Edward Clark	(555) 555-5555

STEP 6: PRESCRIPTION (OPTIONAL)

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: 50kg

☐ Rx **SOLIRIS** 2 mg/mL HCPCS CODE: J1299 PER UNIT
For pediatric patients, you must provide a separate prescription

LOADING DOSE:	MAINTENANCE DOSE:	LOADING DOSE:	MAINTENANCE DOSE:
SIG: INFUSE INTRAVENOUSLY 2400 mg ON DAY 0. COVERS THE PATIENT FOR THE FIRST 2 WEEKS.	SIG: INFUSE INTRAVENOUSLY 3000 mg EVERY 8 WEEKS. START 2 WEEKS AFTER COMPLETION OF LOADING DOSE.	SIG: INFUSE INTRAVENOUSLY ____ mg WEEKLY FOR THE FIRST 4 WEEKS, FOLLOWED BY ____ mg FOR THE FIFTH WEEK.	SIG: INFUSE INTRAVENOUSLY ____ mg EVERY 2 WEEKS. START 2 WEEKS AFTER THE 5TH WEEK'S DOSE IS COMPLETE.
☐ OTHER:	☐ OTHER:	☐ OTHER:	☐ OTHER:
QTY OF 300 mg/3 mL VIALS: 8 REFILLS: 0	QTY OF 300 mg/3 mL VIALS: 10 REFILLS: 6	QTY OF 300 mg/30 mL VIALS: ____ REFILLS: 0	QTY OF 300 mg/30 mL VIALS: ____ REFILLS: ____
☐ **NO LOADING DOSE, PATIENT IS ON THERAPY**	QTY OF 1100 mg/11 mL VIALS: ____ REFILLS: ____	☐ **NO LOADING DOSE, PATIENT IS ON THERAPY**	

☐ **I WOULD LIKE TO TRANSITION MY PATIENT FROM SOLIRIS TO ULTOMIRIS** ANTICIPATED START DATE: ____

STEP 7: PATIENT VACCINATION HISTORY

ULTOMIRIS and SOLIRIS are only available through a restricted program called the **ULTOMIRIS and SOLIRIS REMS (Risk Evaluation and Mitigation Strategy),** because of the risk of serious meningococcal infections.

AFTER YOU COMPLETE THIS FORM:

Provide vaccination history to confirm that the patient has received the appropriate vaccinations or antibacterial drug prophylaxis prior to starting therapy

✓ Enter vaccination information directly in the REMS portal at www.CompUltSolREMS.com

OR

✓ Send VAR (Vaccination Administration Record) via FAX to 1-866-750-0481 or EMAIL to UltSol@AlexionREMS.com

YOU MAY SKIP THIS STEP IF YOU HAVE ALREADY PROVIDED THIS INFORMATION

☑ My patient needs **VACCINATION SUPPORT** from OneSource

STEP 8: PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) I am prescribing the above mentioned product for an on-label diagnosis 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 an authorized prescriber under applicable law 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 permitted under applicable law; (iv) The patient and/or their legal representative is aware of, has consented to, and has authorized my disclosure of their information to OneSource for the scope of the program, including but not limited to benefit investigation and access support. OneSource will contact the patient for completing the enrollment in the program; (v) I am under no obligation to prescribe any Alexion products and I have not received, nor will I receive, any benefit from Alexion for prescribing any products; and (vi) 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)
Kenneth Adams	05/05/2024
PRESCRIBER'S SIGNATURE (NO STAMPS) - **MAY SUBSTITUTE***	DATE (MM/DD/YYYY)

*Only applicable for substitution with other Alexion products as available.

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

PRESCRIBER FORM – PNH/ATYPICAL-HUS

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

ULTOMIRIS® (ravulizumab-cwvz) Injection for Intravenous use 300 mg/30 mL vial
SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial
ONESOURCE® Personalized Patient Support from Alexion

FOR PRESCRIBER

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).

☐ PLEASE PROVIDE SUMMARY OF BENEFIT INVESTIGATION FOR ULTOMIRIS AND SOLIRIS

☐ 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

STEP 5: SITE OF CARE

SELECT OPTION A OR B BELOW:

- ○ **A) PLEASE PROVIDE ASSISTANCE LOCATING AN INFUSION SITE.**
- ○ **B) ASSISTANCE IS NOT NEEDED.** PATIENT WILL BE INFUSED AT: ☐ PRESCRIBER'S OFFICE ☐ INFUSION SITE (specify details below) ☐ HOME (specify specialty pharmacy 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 3 and full Prescribing Information and Medication Guide for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections, also available on www.ULTOMIRIS.com.
Please see Indications & Important Safety Information on page 4 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections, also available on www.SOLIRIS.net.

PRESCRIBER FORM – PNH/ATYPICAL-HUS

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

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

FOR PRESCRIBER

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.

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

☐ **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** 2 mg/mL HCPCS CODE: J1299 PER UNIT

For pediatric patients, you must provide a separate prescription

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: _____

☐ **I WOULD LIKE TO TRANSITION MY PATIENT FROM SOLIRIS TO ULTOMIRIS** ANTICIPATED START DATE: _____

STEP 7: PATIENT VACCINATION HISTORY

ULTOMIRIS and SOLIRIS are only available through a restricted program called the **ULTOMIRIS and SOLIRIS REMS (Risk Evaluation and Mitigation Strategy),** because of the risk of serious meningococcal infections.

AFTER YOU COMPLETE THIS FORM:

Provide vaccination history to confirm that the patient has received the appropriate vaccinations or antibacterial drug prophylaxis prior to starting therapy

✓ Enter vaccination information directly in the REMS portal at www.CompUltSolREMS.com

OR

✓ Send VAR (Vaccination Administration Record) via FAX to 1-866-750-0481 or EMAIL to UltSol@AlexionREMS.com

YOU MAY SKIP THIS STEP IF YOU HAVE ALREADY PROVIDED THIS INFORMATION

☐ My patient needs **VACCINATION SUPPORT** from OneSource

STEP 8: PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) I am prescribing the above mentioned product for an on-label diagnosis 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 an authorized prescriber under applicable law 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 permitted under applicable law; (iv) The patient and/or their legal representative is aware of, has consented to, and has authorized my disclosure of their information to OneSource for the scope of the program, including but not limited to benefit investigation and access support. OneSource will contact the patient for completing the enrollment in the program; (v) I am under no obligation to prescribe any Alexion products and I have not received, nor will I receive, any benefit from Alexion for prescribing any products; and (vi) 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)

*Only applicable for substitution with other Alexion products as available.

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

Please see Indications & Important Safety Information on page 3 and full Prescribing Information and Medication Guide for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections, also available on www.ULTOMIRIS.com.

Please see Indications & Important Safety Information on page 4 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections, also available on www.SOLIRIS.net.

IMPORTANT SAFETY INFORMATION AND INDICATION, INCLUDING BOXED WARNING FOR ULTOMIRIS

INDICATIONS

Paroxysmal Nocturnal Hemoglobinuria (PNH)
ULTOMIRIS is indicated for the treatment of adult and pediatric patients one month of age and older with paroxysmal nocturnal hemoglobinuria (PNH).

Atypical Hemolytic Uremic Syndrome (aHUS)
ULTOMIRIS is indicated for the treatment of adult and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA).

Limitation of Use:
ULTOMIRIS is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

ULTOMIRIS, a complement inhibitor, increases the risk of serious infections caused by *Neisseria meningitidis* [*see Warnings and Precautions (5.1)*] Life-threatening and fatal meningococcal infections have occurred in patients treated with complement inhibitors. These infections may become rapidly life-threatening or fatal if not recognized and treated early.

- **Complete or update vaccination for meningococcal bacteria (for serogroups A, C, W, Y, and B) at least 2 weeks prior to the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal bacteria in patients receiving a complement inhibitor. See *Warnings and Precautions (5.1)* for additional guidance on the management of the risk of serious infections caused by meningococcal bacteria.**
- **Patients receiving ULTOMIRIS are at increased risk for invasive disease caused by *Neisseria meningitidis*, even if they develop antibodies following vaccination. Monitor patients for early signs and symptoms of serious meningococcal infections and evaluate immediately if infection is suspected.**

Because of the risk of serious meningococcal infections, ULTOMIRIS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called ULTOMIRIS and SOLIRIS REMS [*see Warnings and Precautions (5.2)*].

CONTRAINDICATIONS

- Initiation in patients with unresolved serious *Neisseria meningitidis* infection.

WARNINGS AND PRECAUTIONS

Serious Meningococcal Infections
ULTOMIRIS, a complement inhibitor, increases a patient's susceptibility to serious, life-threatening, or fatal infections caused by meningococcal bacteria (septicemia and/or meningitis) in any serogroup, including non-groupable strains. Life-threatening and fatal meningococcal infections have occurred in both vaccinated and unvaccinated patients treated with complement inhibitors.

Revaccinate patients in accordance with ACIP recommendations considering the duration of ULTOMIRIS therapy. Note that ACIP recommends an administration schedule in patients receiving complement inhibitors that differs from the administration schedule in the vaccine prescribing information. If urgent ULTOMIRIS therapy is indicated in a patient who is not up to date with meningococcal vaccines according to ACIP recommendations, provide antibacterial drug prophylaxis and administer meningococcal vaccines as soon as possible. Various durations and regimens of antibacterial drug prophylaxis have been considered, but the optimal durations and drug regimens for prophylaxis and their efficacy have not been studied in unvaccinated or vaccinated patients receiving complement inhibitors, including ULTOMIRIS. The benefits and risks of treatment with ULTOMIRIS, as well as those associated with antibacterial drug prophylaxis in unvaccinated or vaccinated patients, must be considered against the known risks for serious infections caused by *Neisseria meningitidis*.

Vaccination does not eliminate the risk of serious meningococcal infections, despite development of antibodies following vaccination.

Closely monitor patients for early signs and symptoms of meningococcal infection and evaluate patients immediately if infection is suspected. Inform patients of these signs and symptoms and instruct patients to seek immediate medical care if they occur. Promptly treat known infections. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early. Consider interruption of ULTOMIRIS in patients who are undergoing treatment for serious meningococcal infection depending on the risks of interrupting treatment in the disease being treated.

ULTOMIRIS and SOLIRIS REMS
Due to the risk of serious meningococcal infections, ULTOMIRIS is available only through a restricted program called ULTOMIRIS and SOLIRIS REMS.

Prescribers must enroll in the REMS, counsel patients about the risk of serious meningococcal infection, provide patients with the REMS educational materials, assess patient vaccination status for meningococcal vaccines (against serogroups A, C, W, Y, and B) and vaccinate if needed according to current ACIP recommendations two weeks prior to the first dose of ULTOMIRIS. Antibacterial drug prophylaxis must be prescribed if treatment must be started urgently, and the patient is not up to date with both meningococcal vaccines according to current ACIP recommendations at least two weeks prior to the first dose of ULTOMIRIS. Patients must receive counseling about the need to receivemeningococcal vaccines and to take antibiotics as directed, signs and symptoms of meningococcal infection, and be instructed to carry the Patient Safety Card at all times during and for 8 months following ULTOMIRIS treatment.

Further information is available at www.UltSolREMS.com or 1-888-765-4747.

Other Infections
Serious infections with *Neisseria* species (other than *Neisseria meningitidis*), including disseminated gonococcal infections, have been reported.

ULTOMIRIS blocks terminal complement activation; therefore, patients may have increased susceptibility to infections, especially with encapsulated bacteria, such as infections caused by *Neisseria meningitidis* but also *Streptococcus pneumoniae*, *Haemophilus influenzae*, and to a lesser extent, *Neisseria gonorrhoeae*. Children treated with ULTOMIRIS may be at increased risk of developing serious infections due to *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib). Administer vaccinations for the prevention of *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib) infections according to ACIP recommendations. Patients receiving ULTOMIRIS are at increased risk for infections due to these organisms, even if they develop antibodies following vaccination.

Monitoring Disease Manifestations after ULTOMIRIS Discontinuation

Treatment Discontinuation for PNH
After discontinuing treatment with ULTOMIRIS, closely monitor for signs and symptoms of hemolysis, identified by elevated LDH along with sudden decrease in PNH clone size or hemoglobin, or re-appearance of symptoms such as fatigue, hemoglobinuria, abdominal pain, shortness of breath (dyspnea), major adverse vascular event (including thrombosis), dysphagia, or erectile dysfunction. Monitor any patient who discontinues ULTOMIRIS for at least 16 weeks to detect hemolysis and other reactions. If signs and symptoms of hemolysis occur after discontinuation, including elevated LDH, consider restarting treatment with ULTOMIRIS.

Treatment Discontinuation for aHUS
ULTOMIRIS treatment of aHUS should be a minimum duration of 6 months. Due to heterogeneous nature of aHUS events and patient-specific risk factors, treatment duration beyond the initial 6 months should be individualized. There are no specific data on ULTOMIRIS discontinuation. After discontinuing treatment with ULTOMIRIS, patients should be monitored for clinical symptoms and laboratory signs of TMA complications for at least 12 months. TMA complications post-discontinuation can be identified if any of the following is observed: Clinical symptoms of TMA include changes in mental status, seizures, angina, dyspnea, thrombosis or increasing blood pressure. In addition, at least two of the following laboratory signs observed concurrently and results should be confirmed by a second measurement 28 days apart with no interruption: a decrease in platelet count of 25% or more as compared to either baseline or to peak platelet count during ULTOMIRIS treatment; an increase in serum creatinine of 25% or more as compared to baseline or to nadir during ULTOMIRIS treatment; or, an increase in serum LDH of 25% or more as compared to baseline or to nadir during ULTOMIRIS treatment. If TMA complications occur after discontinuation, consider reinitiation of ULTOMIRIS treatment or appropriate organ-specific supportive measures.

Thromboembolic Event Management
The effect of withdrawal of anticoagulant therapy during treatment with ULTOMIRIS has not been established. Treatment should not alter anticoagulant management.

Infusion-Related Reactions
Administration of ULTOMIRIS may result in systemic infusion-related reactions, including anaphylaxis and hypersensitivity reactions. In clinical trials, infusion-related reactions occurred in approximately 1 to 7% of patients, including lower back pain, abdominal pain, muscle spasms, drop or elevation in blood pressure, rigors, limb discomfort, drug hypersensitivity (allergic reaction), and dysgeusia (bad taste). These reactions did not require discontinuation of ULTOMIRIS. If signs of cardiovascular instability or respiratory compromise occur, interrupt ULTOMIRIS and institute appropriate supportive measures.

ADVERSE REACTIONS

Adverse Reactions for PNH
Adverse reactions reported in ≥10% or more of patients with PNH were upper respiratory tract infection and headache. Serious adverse reactions were reported in 15 (6.8%) patients receiving ULTOMIRIS. The serious adverse reactions in patients treated with ULTOMIRIS included hyperthermia and pyrexia. No serious adverse reaction was reported in more than 1 patient treated with ULTOMIRIS. One fatal case of sepsis was identified in a patient treated with ULTOMIRIS. In clinical studies, clinically relevant adverse reactions in 1% of adult patients include infusion-related reactions. Adverse reactions reported in ≥10% of pediatric patients treated with ULTOMIRIS who were treatment-naïve vs. Eculizumab-experienced were anemia (20% vs. 25%), abdominal pain (0% vs. 38%), constipation (0% vs. 25%), pyrexia (20% vs. 13%), upper respiratory tract infection (20% vs. 75%), pain in extremity (0% vs. 25%), and headache (20% vs. 25%).

Adverse Reactions for aHUS
Most common adverse reactions in patients with aHUS (incidence ≥20%) were upper respiratory tract infection, diarrhea, nausea, vomiting, headache, hypertension and pyrexia. Serious adverse reactions were reported in 42 (57%) patients with aHUS receiving ULTOMIRIS. The most frequent serious adverse reactions reported in more than 2 patients (2.7%) treated with ULTOMIRIS were hypertension, pneumonia and abdominal pain.

Adverse reactions reported in ≥20% of pediatric patients treated with ULTOMIRIS were diarrhea, constipation, vomiting, pyrexia, upper respiratory tract infection, decreased vitamin D, headache, cough, rash, and hypertension.

DRUG INTERACTIONS

Plasma Exchange, Plasmapheresis, and Intravenous Immunoglobulins
Concomitant use of ULTOMIRIS with plasma exchange (PE), plasmapheresis (PP), or intravenous immunoglobulin (IVIg) treatment can reduce serum ravulizumab concentrations and requires a supplemental dose of ULTOMIRIS.

Neonatal Fc Receptor Blockers
Concomitant use of ULTOMIRIS with neonatal Fc receptor (FcRn) blockers (e.g., efgartigimod) may lower systemic exposures and reduce effectiveness of ULTOMIRIS. Closely monitor for reduced effectiveness of ULTOMIRIS.

USE IN SPECIFIC POPULATIONS

Pregnancy Exposure Registry
There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ULTOMIRIS during pregnancy. Healthcare providers and patients may call 1-833-793-0563 or go to www.UltomirisPregnancyStudy.com to enroll in or to obtain information about the registry.

To report SUSPECTED ADVERSE REACTIONS, contact Alexion Pharmaceuticals, Inc. at 1-844-259-6783 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see the full Prescribing Information for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections, also available on www.ULTOMIRIS.com.

IMPORTANT SAFETY INFORMATION AND INDICATION, INCLUDING BOXED WARNING FOR SOLIRIS

INDICATIONS

Paroxysmal Nocturnal Hemoglobinuria (PNH)

SOLIRIS is indicated for the treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.

Atypical Hemolytic Uremic Syndrome (aHUS)

SOLIRIS is indicated for the treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy.

Limitation of Use

SOLIRIS is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

SOLIRIS, a complement inhibitor, increases the risk of serious infections caused by *Neisseria meningitidis* [*see Warnings and Precautions (5.1)*]. Life-threatening and fatal meningococcal infections have occurred in patients treated with complement inhibitors. These infections may become rapidly life-threatening or fatal if not recognized and treated early.

- **Complete or update vaccination for meningococcal bacteria (for serogroups A, C, W, Y, and B) at least 2 weeks prior to the first dose of SOLIRIS, unless the risks of delaying SOLIRIS therapy outweigh the risk of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal bacteria in patients receiving a complement inhibitor. *See Warnings and Precautions* (*5.1*) for additional guidance on the management of the risk of serious infections caused by meningococcal bacteria.**
- **Patients receiving SOLIRIS are at increased risk for invasive disease caused by *Neisseria meningitidis*, even if they develop antibodies following vaccination. Monitor patients for early signs and symptoms of serious meningococcal infections and evaluate immediately if infection is suspected.**

Because of the risk of serious meningococcal infections, SOLIRIS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called ULTOMIRIS and SOLIRIS REMS [*see Warnings and Precautions* (*5.2*)].

CONTRAINDICATIONS

- SOLIRIS is contraindicated for initiation in patients with unresolved serious *Neisseria meningitidis* infection.

WARNINGS AND PRECAUTIONS

Serious Meningococcal Infections

SOLIRIS, a complement inhibitor, increases a patient's susceptibility to serious, life-threatening, or fatal infections caused by meningococcal bacteria (septicemia and/or meningitis) in any serogroup, including non-groupable strains. Life-threatening and fatal meningococcal infections have occurred in both vaccinated and unvaccinated patients treated with complement inhibitors.

Revaccinate patients in accordance with ACIP recommendations considering the duration of therapy with SOLIRIS. Note that ACIP recommends an administration schedule in patients receiving complement inhibitors that differs from the administration schedule in the vaccine prescribing information.

If urgent SOLIRIS therapy is indicated in a patient who is not up to date with meningococcal vaccines according to ACIP recommendations, provide the patient with antibacterial drug prophylaxis and administer meningococcal vaccines as soon as possible. Various durations and regimens of antibacterial drug prophylaxis have been considered, but the optimal durations and drug regimens for prophylaxis and their efficacy have not been studied in unvaccinated or vaccinated patients receiving complement inhibitors, including SOLIRIS. The benefits and risks of treatment with SOLIRIS, as well as those associated with antibacterial drug prophylaxis in unvaccinated or vaccinated patients, must be considered against the known risks for serious infections caused by *Neisseria meningitidis*.

Vaccination does not eliminate the risk of serious meningococcal infections, despite development of antibodies following vaccination.

Closely monitor patients for early signs and symptoms of meningococcal infection and evaluate patients immediately if infection is suspected. Inform patients of these signs and symptoms and instruct patients to seek immediate medical care if these signs and symptoms occur. Promptly treat known infections. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early. Consider interruption of SOLIRIS in patients who are undergoing treatment for serious meningococcal infection, depending on the risks of interrupting treatment in the disease being treated.

ULTOMIRIS and SOLIRIS REMS

Due to the risk of serious meningococcal infections, SOLIRIS is available only through a restricted program called ULTOMIRIS and SOLIRIS REMS.

Prescribers must enroll in the REMS, counsel patients about the risk of serious meningococcal infection, provide patients with REMS educational materials, assess patient vaccination status for meningococcal vaccines (against serogroups A, C, W, Y, and B) and vaccinate if needed according to current ACIP recommendations two weeks prior to the first dose of SOLIRIS. Antibacterial drug prophylaxis must be prescribed if treatment must be started urgently and the patient is not up to date with both meningococcal vaccines according to current ACIP recommendations at least two weeks prior to the first dose of SOLIRIS. Patients must receive counseling about the need to receive meningococcal vaccines and to take antibiotics as directed, the signs and symptoms of meningococcal infection, and be instructed to carry the Patient Safety Card with them at all times during and for 3 months following SOLIRIS treatment.

Further information is available at www.UltSolREMS.com or 1-888-765-4747.

Other Infections

Serious infections with *Neisseria* species (other than *Neisseria meningitidis*), including disseminated gonococcal infections, have been reported.

SOLIRIS blocks terminal complement activation; therefore, patients may have increased susceptibility to infections, especially with encapsulated bacteria, such as infections with *Neisseria meningitidis* but also *Streptococcus pneumoniae*, *Haemophilus influenzae*, and to a lesser extent, *Neisseria gonorrhoeae*. Additionally, *Aspergillus* infections have occurred in immunocompromised and neutropenic patients. Children treated with SOLIRIS may be at increased risk of developing serious infections due to *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib). Administer vaccinations for the prevention of *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib) infections according to ACIP recommendations. Patients receiving SOLIRIS are at increased risk for infections due to these organisms, even if they develop antibodies following vaccination.

Monitoring Disease Manifestations After SOLIRIS Discontinuation

Treatment Discontinuation for PNH

Monitor patients after discontinuing SOLIRIS for at least 8 weeks to detect hemolysis.

Treatment Discontinuation for aHUS

After discontinuing SOLIRIS, monitor patients with aHUS for signs and symptoms of thrombotic microangiopathy (TMA) complications for at least 12 weeks. In aHUS clinical trials, 18 patients (5 in the prospective studies) discontinued SOLIRIS treatment. TMA complications occurred following a missed dose in 5 patients, and SOLIRIS was reinitiated in 4 of these 5 patients.

Clinical signs and symptoms of TMA include changes in mental status, seizures, angina, dyspnea, or thrombosis. In addition, the following changes in laboratory parameters may identify a TMA complication: occurrence of 2, or repeated measurement of any one of the following: a decrease in platelet count by 25% or more compared to baseline or the peak platelet count during SOLIRIS treatment; an increase in serum creatinine by 25% or more compared to baseline or nadir during SOLIRIS treatment; or, an increase in serum LDH by 25% or more over baseline or nadir during SOLIRIS treatment.

If TMA complications occur after SOLIRIS discontinuation, consider reinstitution of SOLIRIS treatment, plasma therapy [plasmapheresis, plasma exchange, or fresh frozen plasma infusion (PE/PI)], or appropriate organ-specific supportive measures.

Thrombosis Prevention and Management

The effect of withdrawal of anticoagulant therapy during SOLIRIS treatment has not been established. Therefore, treatment with SOLIRIS should not alter anticoagulant management.

Infusion-Related Reactions

Administration of SOLIRIS may result in infusion-related reactions, including anaphylaxis or other hypersensitivity reactions. In clinical trials, no patients experienced an infusion-related reaction which required discontinuation of SOLIRIS. Interrupt SOLIRIS infusion and institute appropriate supportive measures if signs of cardiovascular instability or respiratory compromise occur.

ADVERSE REACTIONS

Adverse Reactions for PNH

The most frequently reported adverse reactions in the PNH randomized trial (≥10% overall and greater than placebo) were: headache, nasopharyngitis, back pain, and nausea.

Adverse Reactions for aHUS

The most frequently reported adverse reactions in the aHUS single arm prospective trials (≥20%) were: headache, diarrhea, hypertension, upper respiratory infection, abdominal pain, vomiting, nasopharyngitis, anemia, cough, peripheral edema, nausea, urinary tract infections, pyrexia.

DRUG INTERACTIONS

Plasmapheresis, Plasma Exchange, or Fresh Frozen Plasma Infusion

Concomitant use of SOLIRIS with plasma exchange (PE), plasmapheresis (PP), or fresh frozen plasma infusion (PE/PI) treatment can reduce serum eculizumab concentrations and requires a supplemental dose of SOLIRIS.

Neonatal Fc Receptor Blockers

Concomitant use of SOLIRIS with neonatal Fc receptor (FcRn) blockers may lower systemic exposures and reduce effectiveness of SOLIRIS. Closely monitor for reduced effectiveness of SOLIRIS.

To report SUSPECTED ADVERSE REACTIONS contact Alexion Pharmaceuticals, Inc. at 1-844-259-6783 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

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

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