INSTRUCTIONS
FOR HEALTHCARE PROVIDERS

ONESOURCE®
Personalized Patient Support from Alexion

Complete these simple steps for patient support:

PRESCRIBER:

PRESCRIBER FORM

- Fill and sign the required **PRESCRIBER FORM**

VACCINATION ORDER FORM

- For vaccination support, also complete the **VACCINATION ORDER FORM**

PATIENT:

PATIENT CONSENT

- **If patient is in your presence**
  - Ask patient to complete the enclosed **PATIENT ENROLLMENT FORM**
- **If patient is somewhere else**
  - Share this link with the patient to complete the form online:

www.OneSourceConsent.com

MEDICAL OFFICE OR HEALTHCARE TEAM:

SUPPORTING INFORMATION

- Follow the **NEXT STEPS** checklist for submitting any completed forms and additional information needed to facilitate patient support through OneSource

QUESTIONS ABOUT THE FORMS?

Contact OneSource at 1.888.765.4747

PRESCRIBER FORM FOR aHUS, IgAN, and PNH

ONESOURCE CONTACT: PHONE: 1.888.765.4747 8:30 AM to 8 PM ET Mon-Fri | EMAIL: OneSource@Alexion.com | FAX: 1.800.420.5150

ULTOMIRIS® (ravulizumab-cwvz) Injection for intravenous use 300 mg/3 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)	PHONE*	EMAIL

LEGAL REPRESENTATIVE (required if patient is minor*)

NAME (FIRST, LAST)	PHONE	RELATIONSHIP TO PATIENT	EMAIL

STEP 2: CLINICAL DIAGNOSIS

INDICATION (check one)*:

PNH PAROXYSMAL NOCTURNAL HEMOGLOBINURIA

- ☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria

aHUS ATYPICAL HEMOLYTIC UREMIC SYNDROME

- ☐ D59.39 Other hemolytic-uremic syndrome
- ☐ D59.32 Hereditary hemolytic-uremic syndrome

IgAN IMMUNOGLOBULIN A NEPHROPATHY (ULTOMIRIS ONLY)

- ☐ N02.B1 Recurrent and persistent IgAN with glomerular lesion
- ☐ N02.B2 Recurrent and persistent IgAN with focal and segmental glomerular lesion
- ☐ N02.B3 Recurrent and persistent IgAN with diffuse membranoproliferative glomerulonephritis
- ☐ N02.B4 Recurrent and persistent IgAN with diffuse membranous glomerulonephritis
- ☐ N02.B5 Recurrent and persistent IgAN with diffuse mesangial proliferative glomerulonephritis
- ☐ N02.B6 Recurrent and persistent IgAN with diffuse mesangiocapillary glomerulonephritis
- ☐ N02.B9 Other recurrent and persistent IgAN

STEP 3: HEALTHCARE PRESCRIBER INFORMATION

FIRST NAME*	LAST NAME*	EMAIL*
ADDRESS*		PHONE*
CITY*	STATE*	ZIP*
NPI*	TAX ID	OFFICE CONTACT

STEP 4: HEALTH INSURANCE

SELECT ONE* ☐ Patient does not have insurance ☐ I will provide copies of insurance cards

STEP 5: VACCINATION SUPPORT

ULTOMIRIS and SOLIRIS are only available through a restricted program called the **ULTOMIRIS and SOLIRIS Risk Evaluation and Mitigation Strategy (REMS)**, because of the risk of serious meningococcal infections. OneSource can provide **COMPREHENSIVE VACCINATION SUPPORT**, including help with vaccination sites and logistics.

IF REQUIRING **VACCINATION SUPPORT**, select vaccination reason:

- ☐ **A)** Patient is continuing on or starting Alexion therapy immediately or in the next few months (approx. ≤6 months)
- ☐ **B)** Patient is a potential candidate for treatment with a complement inhibitor sometime in the future (approx. >6 months)

If **B)**, skip directly to STEP 7

STEP 6: TREATMENT

IF PRESCRIBING ULTOMIRIS or SOLIRIS, enroll in REMS at www.UltSolREMS.com; DISREGARD if already REMS-enrolled.

PRODUCT (select one)*: ☐ ULTOMIRIS® (ravulizumab-cwvz) ☐ SOLIRIS® (eculizumab)

SITE-OF-CARE ☐ Same as Prescriber Office ☐ Need support identifying a Site-Of-Care

☐ Other Site-Of-Care / Specialty Pharmacy: NAME _____ PHONE _____

STEP 7: PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) If applicable, 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) 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; (iv) 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 (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#privacynotice.

PRESCRIBER'S SIGNATURE (NO STAMPS) DATE (MM/DD/YYYY)

Please see accompanying full Prescribing Information for ULTOMIRIS and SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections.

NEXT STEPS
FOR MEDICAL OFFICE OR HEALTHCARE TEAM

ONESOURCE®
Personalized Patient Support from Alexion

To complete the enrollment process, please review the checklist below:

1 Vaccination Records

- ☐ Send any available meningococcal vaccination administration records (VARs)
  - ↳ Fax **1-866-750-0481** or Email **UltSol@AlexionREMS.com**

2 Submit Form(s) & Insurance Information

- ☐ Prepare health insurance information for OneSource.
  - ↳ Please include <u>both</u> medical (primary and secondary) and pharmacy cards.
- ☐ Send any completed forms and insurance information to OneSource.
  - ↳ Fax 1-800-420-5150 or Email OneSource@alexion.com.

<u>Please do not</u> include any patient medical history.

✓ **TIMELY RECEIPT of information will help patient get the support they need.**

QUESTIONS ABOUT THE FORMS?

Contact OneSource at 1.888.765.4747

INDICATIONS & IMPORTANT SAFETY INFORMATION for ULTOMIRIS® (ravulizumab-cwvz) and SOLIRIS® (eculizumab)

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).

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

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).

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).

Immunoglobulin A Nephropathy (IgAN)
ULTOMIRIS is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression.

This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether ULTOMIRIS slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

ULTOMIRIS and SOLIRIS, complement inhibitors, increase 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 or SOLIRIS, unless the risks of delaying ULTOMIRIS or 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 ULTOMIRIS or 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, ULTOMIRIS and SOLIRIS are 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

- ULTOMIRIS and SOLIRIS are contraindicated for initiation in patients with unresolved serious *Neisseria meningitidis* infection.

WARNINGS AND PRECAUTIONS

Serious Meningococcal Infections

ULTOMIRIS and SOLIRIS, complement inhibitors, increase 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 or SOLIRIS 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 or SOLIRIS 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 and SOLIRIS. The benefits and risks of treatment with ULTOMIRIS or 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 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 or 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, ULTOMIRIS and SOLIRIS are 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 2 weeks prior to the first dose of ULTOMIRIS or 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 2 weeks prior to the first dose of ULTOMIRIS or SOLIRIS. Patients must receive counseling about the need to receive meningococcal 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 or 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.

ULTOMIRIS and SOLIRIS block 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*. Additionally, with SOLIRIS, *Aspergillus* infections have occurred in immunocompromised and neutropenic patients. Children treated with ULTOMIRIS or 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 ULTOMIRIS or SOLIRIS are at increased risk for infections due to these organisms, even if they develop antibodies following vaccination.

Monitoring Disease Manifestations After ULTOMIRIS or SOLIRIS Discontinuation

Treatment Discontinuation for PNH
After discontinuing treatment with **ULTOMIRIS**, closely monitor for signs and symptoms of hemolysis, identified by elevated lactate dehydrogenase (LDH) along with sudden decrease in PNH clone size or hemoglobin, or reappearance 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.

After discontinuing treatment with **SOLIRIS**, monitor patients for at least 8 weeks to detect hemolysis.

Treatment Discontinuation for aHUS
ULTOMIRIS treatment of aHUS should be a minimum duration of 6 months. Due to the 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 including changes in mental status, seizures, angina, dyspnea, thrombosis or increasing blood pressure. In addition, at least 2 of the following laboratory signs observed concurrently and results 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 lactate dehydrogenase (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.

After discontinuing **SOLIRIS**, monitor patients with aHUS for signs and symptoms of 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

Please see accompanying full Prescribing Information for ULTOMIRIS and SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections.

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.

Thromboembolic Event Management

The effect of withdrawal of anticoagulant therapy during treatment with ULTOMIRIS or SOLIRIS 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 8% 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.

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

For ULTOMIRIS, adverse reactions reported in ≥10% 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 for PNH 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%).

For SOLIRIS, 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

For ULTOMIRIS, the 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 for aHUS were diarrhea, constipation, vomiting, pyrexia, upper respiratory tract infection, decreased vitamin D, headache, cough, rash, and hypertension.

For SOLIRIS, 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.

Adverse Reactions for IgAN

For ULTOMIRIS, the most common adverse reaction in adult patients with IgAN (incidence ≥10%) was upper respiratory tract infection. Serious adverse reactions were reported in 11 (4.6%) patients with IgAN receiving ULTOMIRIS and in 22 (9.0%) patients receiving placebo.

DRUG INTERACTIONS

Plasma Exchange, Plasmapheresis, Fresh Frozen Plasma Infusion, 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.

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

Neonatal Fc Receptor Blockers

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

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 accompanying full Prescribing Information for ULTOMIRIS and SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections.

CONTACT US

PHONE: 1.888.765.4747
8:30 AM to 8 PM ET, Monday-Friday

EMAIL: OneSource@Alexion.com

WEBSITE: AlexionOneSource.com

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

ALEXION, ULTOMIRIS, SOLIRIS, and the OneSource logo are registered trademarks and OneSource is a trademark of Alexion Pharmaceuticals, Inc.
© 2026, Alexion Pharmaceuticals, Inc. All rights reserved. US/ULT-P/0343 V6 09/2026

PATIENT SERVICES ENROLLMENT FORM

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

ONESOURCE®
Personalized Patient Support from Alexion

FOR PATIENT

WE'RE HERE TO HELP EVERY STEP OF THE WAY

OneSource™ is a free, personalized patient support program offered by Alexion and is designed to support patients' specific needs. Whether just starting or continuing an Alexion treatment, we can help you understand your or your loved one's condition, navigate insurance coverage, provide information about options for financial support, connect you with others who can relate, and more.

For more information, visit **www.AlexionOneSource.com**.

Complete this form to get started with support!

INSTRUCTIONS FOR PATIENTS:

To enroll in OneSource, please follow these steps:

1. **Read** the Authorization to Share Health Information Terms on **this page**
2. **Complete** all required information on **Page 2**
3. **Email or fax Page 2** and copies of the front and back of your medical insurance and pharmacy coverage cards **to OneSource**
   Email: OneSource@Alexion.com | **Fax:** 1.800.420.5150

PREFER TO COMPLETE THE FORM DIGITALLY?

Scan the QR Code

or visit
www.AlexionOneSource.com

AUTHORIZATION TO SHARE HEALTH INFORMATION TERMS

Alexion Pharmaceuticals, Inc. ("Alexion") offers patient services including educational resources, case management support, and financial assistance for eligible patients.

By signing the next 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 insurance coverage and 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 vaccination services;
- provide me with educational and promotional materials, contact me about market research or clinical studies, or otherwise contact me about Alexion products, services, programs, or other topics that Alexion thinks may interest me
- remove identifiers from My Information and combine such resulting information with other information for research, regulatory submissions, business improvement projects, and publication purposes; and
- (as applicable to my Alexion product) review my vaccination and prophylaxis history and provide corresponding patient support, such as sending reminders about potential upcoming vaccinations.

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 be subject to redisclosure.

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.

PATIENT SERVICES ENROLLMENT FORM

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

ONESOURCE®
Personalized Patient Support from Alexion

FOR PATIENT

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 have fully completed and submitted this form.

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

NOTE TO PRESCRIBERS: If you are sending this form to a specialty pharmacy, please include **BOTH pages 1 and 2**

Fields in red with asterisks are required.*

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)*	DATE OF BIRTH (MM/DD/YYYY)*	GENDER: ☐ MALE ☐ FEMALE ☐ NON-BINARY PREFER TO SELF-DESCRIBE:
ADDRESS*		
CITY*	STATE*	ZIP*
PRIMARY PHONE NUMBER* ☐ MOBILE ☐ HOME	OK TO SEND TEXT MESSAGES FOR PATIENT SUPPORT? ☐ 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 previous 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/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 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)

This material is intended only for residents of the United States.
ALEXION, the Alexion logo, and the OneSource logo are registered trademarks and OneSource is a trademark of Alexion Pharmaceuticals, Inc. © 2025, Alexion Pharmaceuticals, Inc. All rights reserved.
US/ALL/0473 V4 03/2025

ALEXION
AstraZeneca Rare Disease

PRESCRIBER VACCINATION ORDER FORM

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

ONESOURCE® Personalized Patient Support from Alexion

FOR VACCINATION SUPPORT

PATIENT INFORMATION

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

HEALTHCARE PRESCRIBER INFORMATION

FIRST NAME	LAST NAME	PHONE NUMBER	FAX NUMBER
ADDRESS	CITY	STATE	ZIP
OFFICE CONTACT NAME		NPI	

CLINICAL INFORMATION

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

IN COMPLIANCE WITH THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP), MENINGOCOCCAL VACCINATIONS SHOULD BE COMPLETED OR UPDATED IN ADVANCE OF INITIATING COMPLEMENT INHIBITOR THERAPY; THOSE WHO REMAIN AT A HIGH RISK NEED BOOSTER DOSES.

ACIP recommends that adults and children over 10 years old at increased risk receive both types of meningococcal vaccines (MenACWY and MenB). Vaccines should be completed or updated at least 2 weeks prior to first dose of Alexion Complement Inhibitor unless the risks of delaying treatment outweigh the risks of developing meningococcal disease. The below list is not exhaustive and is intended to provide an example of most commonly prescribed meningococcal vaccines. The choice of vaccine brand deemed medically appropriate is the decision of the treating healthcare provider.

ONE (1) REQUIRED FROM EACH GROUP

MenACWY

MenACWY vaccine the patient needs to receive (pick ONE):

- ☐ **MenQuadfi** (meningococcal groups A,C,W and Y polysaccharide tetanus toxoid conjugate vaccine [MenACWY-TT]) 90619

OR

- ☐ **Menveo** (meningococcal groups A,C,W, and Y oligosaccharide diphtheria CRM conjugate vaccine [MenACWY-CRM]) 907340

Dosing Schedule (MenQuadfi or Menveo)

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

OR

☐ **Booster Dose**

AND

MenB

MenB vaccine the patient needs to receive (pick ONE):

- ☐ **Bexsero** (MenB-4C) 90620

OR

- ☐ **Trumenba** (MenB-FHbp) 9062

Dosing Schedule (Bexsero or Trumenba)

☐ **Dose 1:** Day 0 ☐ **Dose 2:** 1-2 months after Day 0 ☐ **Dose 3:** 6 months after Day 0

OR

☐ **Booster Dose**

MenB vaccines are not interchangeable. Patient must receive the same product for all doses during vaccination series. For the full vaccine schedule, including the vaccination schedule for children ≤ 10 years old, please refer to the ACIP vaccine recommendations or to Alexion medical information.

Per ACIP recommendations, those who remain at increased risk need regular booster doses. MenACWY: For children under the age of 7 years, administer a booster dose 3 years after completion of the primary series and every 5 years thereafter. For children 7 years old or older and adults, administer a booster dose 5 years after completion of the primary series and every 5 years thereafter. MenB: Administer a booster dose of vaccine 1 year after series completion and then every 2 to 3 years thereafter.

Note: All vaccines listed above are administered intramuscularly at a dose of 0.5 mL.

☐ I would like to prescribe a pentavalent vaccination and I will provide my own prescription

☐ I would like to be contacted by a Medical Science Liaison (MSL) for medical or scientific information

ANCILLARY ORDERS (HOME ADMINISTRATION ONLY – USE AS NEEDED)

Anaphylaxis Kit - The following items will be dispensed:

☑ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN

☑ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement

☑ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis

General Anaphylaxis Instructions

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

PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) the vaccines are medically necessary based on my clinical judgment that the patient is currently receiving, will initiate, or is a potential candidate for complement C5 inhibitor therapy in the future; (ii) the patient has an on-label diagnosis for an Alexion C5 inhibitor; (iii) I am authorized under applicable law to prescribe the vaccines identified and I have verified and complied with all applicable prescription requirements; (iv) I am authorizing Alexion to forward the patient's prescription to a pharmacy by any means under applicable law; (v) I am under no obligation to prescribe the vaccines identified and I have not received, nor will I receive, any benefit from Alexion; (vi) I am under no obligation to prescribe any Alexion products now or in the future; and (vii) the information provided on this form is complete, current, and accurate to the best of my knowledge.

SIGN ONE

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

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

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

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

ALEXION and the OneSource logo are registered trademarks and OneSource is a trademark of Alexion Pharmaceuticals, Inc.

© 2026, Alexion Pharmaceuticals, Inc. All rights reserved. US/ALL/0475 V6 07/2026