Alexion OneSource™ CoPay Program Enrollment Form

Please complete fields and have patient sign prior to submitting to OneSource™.

For more information on the Alexion OneSource CoPay Program enrollment process, contact OneSource at 1.888.765.4747 or via email at OneSource@Alexion.com.

Indication: ☐ gMG ☐ NMOSD ☐ PNH ☐ aHUS ☐ LAL-D Product: ____________________

Expected treatment start date (MM/DD/YYYY): ______ /______ /______

STEP 1: HEALTHCARE PROVIDER INFORMATION

Prescriber name: ____________________

Practice name: ____________________

Address: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

NPI #: ____________________ Group NPI #: ____________________

State license #: ____________________ Tax ID #: ____________________

Office contact for follow-up: ____________________

Phone: (______)____________________ Fax: (______)____________________

Email: ____________________

STEP 2: SITE OF CARE INFORMATION

Billing site for claim: ☐ HCP office ☐ Infusion site Specialty pharmacy: ☐ Yes ☐ No

Place of infusion *(check all that apply)*:

☐ Healthcare provider's office ☐ Other *(complete infusion site details below)*

Infusion site name: ____________________

Infusion site tax ID #: ____________________ Infusion site NPI #: ____________________

Address: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Phone: (______)____________________ Email: ____________________

STEP 3: PATIENT INFORMATION

Patient name: ____________________

Date of birth: ____________________ Gender: ☐ M ☐ F

Address: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Phone: (______)____________________ OK to leave voicemail? ☐ Yes ☐ No

Email: ____________________

Patient's preferred language (if not English): ____________________

Please complete pages 1 and 2 and fax to OneSource at 1.800.420.5150 or email to OneSource@Alexion.com. Patient should keep remaining pages for their records.

US/ALL/0073

Patient name: ______________________ Date of birth: ______________________

STEP 3: PATIENT INFORMATION (continued)

Primary insurance name: ______________________ Phone: (____)__________

Policyholder name: ______________________

Policy ID #: ______________________ Group #: ______________________

Secondary insurance name: ______________________ Phone: (____)__________

Policyholder name: ______________________

Policy ID #: ______________________ Group #: ______________________

STEP 4:

CoPay Program Enrollment (program required)

By signing below, you acknowledge that you have read and agree with the Alexion OneSource CoPay Program Terms and Conditions on pages 5 to 6.

X ______________________ ______________

Signature of patient or designated representative Date

OneSource Enrollment (program required)

By signing below, you acknowledge that you have read and agree with the OneSource Enrollment and Authorization on pages 3 to 4 and that you authorize the release of your information by providers and payers.

X ______________________ ______________

Signature of patient or designated representative Date

Alexion Communications Opt-in (optional)

By signing below, you voluntarily opt in to receive communications from Alexion and acknowledge that you have read and agree with the Alexion Communications Authorization on page 4.

X ______________________ ______________

Signature of patient or designated representative Date

Designated Representative

(Please fill out this section ONLY if the person signing this Authorization Form is not the patient.)

Name of person authorizing release: ______________________

Relationship to patient: ______________________ Phone: (____)__________

Check one: ☐ Home ☐ Mobile ☐ Work ☐ Other ______________

Email: ______________________

For Alexion Use Only: PM Number ______________________

Please complete pages 1 and 2 and fax to OneSource at 1.800.420.5150 or email to OneSource@Alexion.com. Patient should keep remaining pages for their records.

OneSource Enrollment and Authorization

Authorization to Receive Patient Services and Communications

I (or my representative) authorize Alexion Pharmaceuticals, Inc., including, but not limited to, its affiliates, business partners, employees, subcontractors, agents, designees, and other representatives (together, "Alexion" or "we") to provide me with patient support services related to any of Alexion's products including, but not limited to, online support, insurance coverage verification and additional financial assistance services, education regarding the medical conditions that are approved as listed in the U.S. Prescribing Information, compliance and persistency services, and other therapy support services, as well as any information or materials related to such services (the "services").

I (or my representative) agree and acknowledge that any Alexion personnel providing such support services are not employed by my healthcare professional, nor are any Alexion personnel providing medical treatment or advice.

Authorization to Use and Disclose My Personal Information

I (or my representative) agree to permit the Authorized Parties listed below to disclose information that may identify me ("Personal Information"), including certain health information, to Alexion for the uses described below. I understand that my participation in the OneSource Program is subject to Alexion's Privacy Notice, available at **https://alexion.com/Legal#privacy**, which provides me with additional information about Alexion's privacy practices and the privacy rights that may be available to me.

The Authorized Parties include, but are not limited to, the following: (1) Me (or my representative); (2) My primary care physician, evaluating and/or treating physician, and any specialist or other healthcare providers involved in my treatment ("Providers"); (3) The distributor, pharmacy, hospital/infusion site/treatment site, or home health agency that dispenses my medical therapy ("Distributors"); and (4) My health insurer, payer, or patient assistance program ("Payers").

The Personal Information that may be collected, disclosed or used includes name, address, other contact information, date of birth, last four of your Social Security number, medical reports and treatment history, orders, diagnosis, prescriptions and records, histories, findings, prognoses, plans of care and discharge summaries, billing information, insurance claims, and utilization review reports, as well as any other Personal Information you (or your representative), your healthcare provider, insurance company or other Authorized Party provided to Alexion in the course of your interaction with the OneSource program. When feasible, we will endeavor to use and disclose your Personal Information in anonymized or de-identified form.

The Authorized Parties may disclose my Personal Information to Alexion, so that Alexion may collect, disclose or use the Personal Information for the following purposes:

1. **Coordination of care:** Between me, the Providers, Distributors, or Payers for the coordination of my medical care, including therapy adherence reminders.
2. **Disease management/patient education:** To provide information, training, and case management services to me (or my representative), and any Providers, Payers, and Distributors.
3. **Clinical research, treatment protocols, and/or meetings:** To inform and refer me (or my representative) of Alexion-sponsored clinical research studies, treatment protocols, or disease-related surveys that may benefit me and/or meetings that may be of interest to me.
4. **Reviewing insurance benefits/plan and/or funding options:** To review, co-verify, and assist me (or my representative) in understanding the benefits provided by my Payer, to verify what services my Payer benefits cover and help me obtain the services ordered by my Provider, to coordinate benefits, to determine appeal requirements, and to identify other sources of payment or financial support, if necessary.
5. **Billing and payment:** To coordinate the preparation, filing, and processing of health insurance claims, and the evaluation of coding (billing) issues, and to assist and escalate (including engaging appropriate third parties) with the resolution of any claims issues relating to my therapy.
6. **Distribution of therapy:** To coordinate the distribution of medical therapy to me.
7. **Product orders:** To fulfill any product orders and answer any questions that I (or my representative) may provide to the Alexion call center, and otherwise to inform me (or my representative) about other services that may be of interest to me (or my representative).

8. **Government agencies:** To provide information as required or requested by representatives of government agencies, review boards, and others who watch over the safety of drugs (or operations) of pharmaceutical manufacturers.
9. **Contact:** To contact me (or my representative) by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system), and other mutually agreed-upon means.
10. **Other uses of Personal Information:** To use my Personal Information to perform research, patient and community education/engagement and disease awareness, clinical protocol development, or marketing studies, or for other commercial purposes as determined by Alexion.

Sharing of My Personal Information

The additional Authorized Parties that Alexion might work with are:

1. Vendors and service providers who assist Alexion with providing the services, like training, delivery, and other services and purposes as described above;
2. Third parties in connection with the sale, assignment or other transfer of Alexion's business or product lines;
3. Governmental representatives and advocacy groups to engage in disease education, awareness, and/or discussions related to coverage;
4. Third parties to respond to requests of government or law enforcement agencies or where required or permitted by applicable laws, court orders, or government regulations; or
5. When needed for audits or to investigate or respond to a complaint or security threat.

Alexion will not disclose your Personal Information to Authorized Parties without adequate organizational and technical measures in place in order to protect your Personal Information.

Notice

Alexion takes seriously our responsibility to protect the Personal Information entrusted to us. As such, we use appropriate privacy and security controls and processes that are reasonably designed to help protect and safeguard your Information when collecting, using or disclosing it for the purposes described in this Authorization Form or as permitted by law. I understand that I do not have to sign this Authorization and that if I do not sign this Authorization Form, or choose to revoke it, my ability to obtain medical care and/or therapy, or my eligibility or enrollment for insurance benefits will not be affected. However, if I do not sign this Authorization Form, Alexion will not be able to provide the OneSource services described above.

I verify that the information provided is current, complete and accurate to the best of my knowledge. I also understand that my enrollment in the OneSource program should not influence treatment/prescription decisions. The OneSource program does not have any obligation to provide all the OneSource services described here to you.

I (or my representative) have read and understand the terms of this Form, and the Alexion Privacy Notice, and authorize Alexion to collect, use, store, transfer, and disclose my Personal Information as described in this Authorization Form. This authorization shall remain in effect for ten (10) years unless it is revoked (taken back) by me (or my representative). I (or my representative) may revoke this authorization at any time in writing, which would include verified email or fax, which includes my name and address, to Alexion Pharmaceuticals, Inc. at the address, email or fax listed on this form. I (or my representative) have the right to receive a copy of this Authorization Form upon request.

Alexion Communications Authorization (optional)

I (or my representative) also authorize Alexion and certain Authorized Parties to send me communications, such as mailing, emails, newsletters, or invitations to events about Alexion, our products, and OneSource services. I understand that my consent is not required for me to enroll in OneSource and that I may opt out of these communications at any time by either contacting my Case Manager or Alexion via the link/contact information available in all communications.

Alexion OneSource CoPay Program Terms and Conditions

The Alexion OneSource™ Copay Program (the "Program") pays for eligible out-of-pocket medication and infusion costs associated with Soliris® (eculizumab) or ULTOMIRIS® (ravulizumab-cwvz) up to $15,000 US dollars per calendar year. After reaching the maximum Program benefit, the patient will be responsible for any remaining out-of-pocket costs incurred during that calendar year.

The Program is valid ONLY for patients with commercial insurance who have a valid prescription for a U.S. Food and Drug Administration-approved indication for SOLIRIS or ULTOMIRIS. The Program is not valid for costs eligible to be reimbursed, in whole or in part, by government insurance programs, including Medicaid, Medicare (including Medicare Part D), Medicare Advantage Plans, Medigap, Veterans Affairs, Department of Defense or TRICARE, or other federal or state programs (including any state prescription drug assistance programs). Patients residing in Massachusetts, Michigan, Minnesota, and Rhode Island are eligible for assistance with medication costs, but are not eligible for assistance with infusion costs. No claim for reimbursement of any out-of-pocket expense amount covered by the Program may be submitted to any third-party payer, whether public or private.

To enroll in the Program, the patient must also enroll in OneSource™, a personalized patient support program offered by Alexion and must be a citizen or permanent resident of the United States or its territories. In addition, the person who is financially responsible for the patient's copay must be 18 years of age or older.

Claims must be submitted in a timely manner. An explanation of benefits or similar documentation from the patient's commercial health insurance must be submitted within 120 days of the date of service for the patient to receive out-of-pocket assistance. The Program will not pay for claims with a date of service that precedes the patient's enrollment in the Program by more than 90 days. In addition, the Program will not pay for claims with a date of service prior to the effective date of the Program, July 27, 2020.

Program participants and providers are responsible, as applicable, for reporting receipt of the Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Program, or as may otherwise be required by law.

Program participants are required to immediately inform OneSource™ if the patient's insurance changes or if the patient is no longer eligible to receive Program benefits. If a patient moves from commercial insurance to government-supported insurance during a calendar year, that patient will no longer be eligible to receive Program benefits.

This Program is not health insurance or a benefit plan. The Program does not obligate the use of any specific medication or health care provider. This Program cannot be combined with any other rebate, coupon, free trial, or similar offer. Participation in the Program is not conditioned on any past, present, or future purchase. Program benefits may not be sold, purchased, traded, or offered for sale, purchase, or trade. The Program is not valid where prohibited by law, taxed, or otherwise restricted.

In addition, Program participants acknowledge and agree that their personal information will be collected, used, and disclosed in accordance with the Alexion Privacy Notice, available at **https://alexion.com/Legal#privacy**, and the OneSource Enrollment and Authorization Form, available at **https://alexiononesource.com** which collectively provide information about Alexion's privacy practices and the privacy rights that may be available to Program participants. Program participants authorize Alexion and its affiliates, business partners, employees, subcontractors, agents, designees, and other representatives to (i) use and share information with their healthcare providers, specialty pharmacies, insurers and others for the purposes of coordinating enrollment and participation in the Program; (ii) contact them by mail, telephone and/or email in connection with the Program; and (iii) inform them of available assistance programs, treatment and therapies and insurance-related information.

This is a voluntary program. Patients may choose not to enroll in the Program and will still receive medication. Patients may participate in OneSource without being a member of the Program. After enrolling in the Program, Program participants may later opt out of the Program at any time by contacting OneSource. By participating in the Program, Program participants acknowledge that they understand and agree to comply with these Terms and Conditions. Alexion reserves the right to rescind, revoke, or amend the Program and these Terms and Conditions without notice.

Please see Important Safety Information and full Prescribing Information and Medication Guide for Soliris, including Boxed WARNING regarding serious and life-threatening meningococcal infections, at www.Soliris.net.

Please see Important Safety Information and full Prescribing Information and Medication Guide for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis, at www.ULTOMIRIS.com.

For more information, visit **AlexionOneSource.com** or call **1.888.765.4747**.

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