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.

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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.

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ALEXION
AstraZeneca Rare Disease