PATIENT START FORM – NEUROLOGY

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

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial | ONESOURCE® Personalized Patient Support from Alexion

Steps to enroll in patient support programs:

1. Fill out the **PATIENT INFORMATION** section below.
2. Patients to read the "Authorization to Share Health Information" agreement on **PAGE 2 and sign below**.
3. The completed form should be emailed or faxed to OneSource™. Remember to also send OneSource™ copies of your medical insurance and pharmacy coverage cards.

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)		
DATE OF BIRTH (MM/DD/YYYY)	ADDRESS	
CITY	STATE	ZIP
PREFERRED PHONE NUMBER	BEST TIME TO CONTACT ☐ MORNING ☐ AFTERNOON ☐ EVENING	PREFERRED LANGUAGE
OK TO LEAVE A PHONE MESSAGE? ☐ YES ☐ NO OK TO SEND A TEXT MESSAGE? ☐ YES ☐ NO	EMAIL	
LEGALLY AUTHORIZED REPRESENTATIVE (OPTIONAL) NAME:	RELATIONSHIP TO PATIENT:	
PHONE NUMBER	EMAIL	
OTHER PERSON WITH WHOM WE CAN SHARE YOUR HEALTH INFORMATION (OPTIONAL) NAME:	RELATIONSHIP TO PATIENT:	
PHONE NUMBER	EMAIL	

PRESCRIBING PHYSICIAN'S INFORMATION

PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S PHONE NUMBER

ENROLLMENT IN PATIENT SUPPORT PROGRAM AND AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I acknowledge my intent to enroll in the Alexion Patient Support Program, including the Alexion OneSource™ CoPay Program, and that I have read and agree with the Authorization to Share Health Information and Alexion OneSource™ CoPay Program eligibility terms on the next page. I understand that I may decline to share my information by choosing not to sign this form, and that refusing to share my information will not affect my treatment, insurance enrollment, or eligibility for insurance benefits. I also understand that refusing to sign this form will make me ineligible to participate in these programs.

CONSENT FOR PROMOTIONAL COMMUNICATIONS (OPTIONAL)

☐ By checking this box, I give Alexion and companies working at Alexion's direction permission to use my contact information to provide promotional information to me about Alexion products, services, programs, or other topics that Alexion thinks may interest me. I understand that Alexion will use and share my information in accordance with the Privacy Notice on the Alexion website at https://alexion.com/Legal#privacy.

SIGN HERE

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE | DATE (MM/DD/YYYY)

CONSENT FOR AUTOMATED TEXT COMMUNICATIONS (OPTIONAL)

By signing below, I give Alexion and companies working at Alexion's direction permission to use automated text (SMS) messages to provide patient support services and to provide information to me about Alexion products, services, programs, or other topics that Alexion thinks may interest me. I understand that (i) I am not required to consent to receiving text messages as a condition of any purchase of Alexion products or enrollment in these programs; (ii) my telecommunication services provider may charge me for any text messages that I receive from Alexion; and (iii) I may opt out of receiving automated text messages from Alexion at any time without affecting my enrollment in these programs.

SIGN HERE

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE | DATE (MM/DD/YYYY)

Please see Indications & Important Safety Information on page 6 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

US/SOL-g/0289 05/21

AUTHORIZATION TO SHARE HEALTH INFORMATION

Alexion Pharmaceuticals, Inc. ("Alexion") offers patient services that include (but are not limited to) educational resources, case management support, and financial assistance for eligible patients.

By signing on the prior page, I give permission for my healthcare providers, health plans, and pharmacies ("My Healthcare Entities") to share personal information relating to my medical condition, treatment, and health insurance coverage ("My Information") with Alexion and companies working at its direction so that Alexion may:

- obtain information from my health plan or other insurance programs to review my eligibility for benefits for treatment with an Alexion product;
- coordinate treatment with an Alexion product with My Healthcare Entities;
- if needed to assess eligibility for financial assistance programs, access my credit information and information from other sources to estimate my income;
- remove identifiers from My Information and combine My Information with other information for research, regulatory submissions, business improvement projects, and publication purposes; and
- contact me to assess my interest in participating in market research or clinical studies.

If I ask Alexion to arrange services relating to my treatment with new healthcare service providers (for example, vaccine services or home infusion services), I give permission for Alexion to share My Information with the new healthcare providers as needed to arrange for the services and coordinate treatment. I also give my permission for these healthcare service providers to share My Information with Alexion. I understand that these healthcare service providers 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 intends to protect My Information by using and disclosing it only for purposes authorized in this authorization, the Alexion Privacy Notice, or as required by law, I understand that once My Information has been disclosed to Alexion, U.S. and state laws may not apply, and may no longer protect the information.

I understand that I may cancel my authorization at any time by mailing a letter to Alexion OneSource™ Patient Support Program, 121 Seaport Blvd, Boston, MA 02210 or by emailing OneSource@Alexion.com. I also understand that canceling my authorization will not affect any use or disclosure of My Information that occurred before Alexion received notice of my cancellation.

This Authorization expires ten (10) years from the date next to my signature, unless I revoke it sooner, or unless a shorter time frame is required by applicable law. I understand I have a right to receive a copy of this authorization after it is signed.

ALEXION ONESOURCE™ COPAY PROGRAM ELIGIBILITY

The Alexion OneSource™ CoPay Program pays for eligible out-of-pocket medication and infusion costs, where applicable, associated with a qualifying Alexion product up to $15,000 US dollars per calendar year. This 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 the qualifying Alexion product. By participating in the program, participants acknowledge that they understand and agree to comply with the complete program terms and conditions available at https://alexiononesource.com/CoPay or on request by contacting OneSource™ at 1.888.765.4747.

Please see Indications & Important Safety Information on page 6 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

PRESCRIBER START FORM – NEUROLOGY

FAX: 1.800.420.5150 **MAIL:** 100 College St., New Haven, CT 06510

EMAIL: OneSource@Alexion.com **PHONE:** 1.888.765.4747
8:30 AM to 8 PM ET Monday-Friday

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial

ONESOURCE® Personalized Patient Support from Alexion

Steps to complete enrollment:

1 The prescriber should fill out **PAGES 3, 4, and 5**.

2 The prescriber should fax or email completed **PAGES 1, 3, 4, and 5** and copies of the patient's insurance cards.

Prescriber's signature is required in order to fill a SOLIRIS prescription.

STEP 1: PATIENT INFORMATION AND DIAGNOSIS

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	
DATE OF BIRTH (MM/DD/YYYY)	SEX: ☐ MALE ☐ FEMALE
DIAGNOSIS: ☐ gMG ☐ NMOSD	ANTIBODY STATUS: ☐ ANTI-AChR ANTIBODY POSITIVE (gMG) ☐ ANTI-AQP4 ANTIBODY POSITIVE (NMOSD)
DATE OF DIAGNOSIS: (MM/DD/YYYY)	

STEP 2: CLINICAL INFORMATION

CHECK ALL PREVIOUS GENERALIZED MYASTHENIA GRAVIS (gMG) THERAPIES:

☐ AZATHIOPRINE ☐ PLASMAPHERESIS ☐ OTHER
☐ IVIg ☐ PREDNISONE ☐ RITUXIMAB
☐ MYCOPHENOLATE MOFETIL ☐ PYRIDOSTIGMINE

CHECK ALL PREVIOUS NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD) THERAPIES:

☐ AZATHIOPRINE ☐ MITOXANTRONE ☐ RITUXIMAB
☐ CYCLOPHOSPHAMIDE ☐ MYCOPHENOLATE MOFETIL ☐ SATRALIZUMAB
☐ INEBILIZUMAB ☐ OTHER ☐ STEROID
☐ METHOTREXATE

MGFA CLASSIFICATION:	NUMBER OF RELAPSES IN LAST 12 MONTHS: 24 MONTHS:
CURRENT MG-ADL SCORE:	EDSS SCORE:

Abbreviations: AChR, acetylcholine receptor; EDSS, Expanded Disability Status Scale; gMG, generalized myasthenia gravis; IVIg, intravenous immunoglobulin; MG-ADL, Myasthenia Gravis Activities of Daily Living; MGFA, Myasthenia Gravis Foundation of America; NMOSD, neuromyelitis optica spectrum disorder.

STEP 3: HEALTHCARE PRESCRIBER INFORMATION

FIRST NAME	LAST NAME	CREDENTIALS
PRACTICE NAME		PHONE NUMBER
ADDRESS		
CITY	STATE	ZIP
NPI #	TAX ID #	EMAIL
OFFICE CONTACT	PHONE NUMBER	FAX NUMBER

STEP 4: SITE OF CARE INFORMATION

☐ I NEED HELP FINDING A SITE OF CARE CENTER FOR MY PATIENT ☐ CONTACT MY PATIENT DIRECTLY FOR SITE OF CARE SUPPORT

IF YOU DO NOT NEED SUPPORT, PLEASE COMPLETE THE REMAINDER OF STEP 4 BELOW.

MY PATIENT'S SITE OF CARE LOCATION: ☐ PRESCRIBER'S OFFICE ☐ AT HOME ☐ INPATIENT ☐ OUTPATIENT OFF CAMPUS ☐ OUTPATIENT ON CAMPUS

SITE OF CARE NAME	SITE OF CARE TAX ID #	SITE OF CARE NPI #
ADDRESS		
CITY	STATE	ZIP
OFFICE CONTACT FOR FOLLOW-UP	SHIP PRODUCT TO: ☐ HEALTHCARE PRESCRIBER'S OFFICE ☐ SITE OF CARE ABOVE ☐ THIS ADDRESS:	

STEP 5: INSURANCE INFORMATION

BILLING SITE FOR CLAIM: ☐ HCP ☐ SITE OF CARE

PRIMARY INSURANCE NAME		SECONDARY INSURANCE HOLDER	
POLICYHOLDER NAME		POLICYHOLDER NAME	
PHONE NUMBER	POLICYHOLDER DOB (MM/DD/YYYY)	PHONE NUMBER	POLICYHOLDER DOB (MM/DD/YYYY)
POLICY ID #	GROUP #	POLICY ID #	GROUP #

Please see Indications & Important Safety Information on page 6 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

PRESCRIBER START FORM – NEUROLOGY

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

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial

ONESOURCE® Personalized Patient Support from Alexion

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	DATE OF BIRTH (MM/DD/YYYY)

STEP 6: PHARMACY COVERAGE

PRESCRIPTION INSURANCE	POLICY ID #
INSURANCE PHONE NUMBER	RX GROUP #
RX BIN #	RX PCN #

STEP 7: VACCINATION INFORMATION AND SUPPORT

SELECT YOUR PATIENT'S VACCINATION STATUS:

A ☐ PATIENT IS ALREADY SCHEDULED FOR VACCINATIONS BY A HEALTHCARE PROVIDER

B ☐ PATIENT HAS RECEIVED VACCINATIONS **(CHECK ALL MENINGOCOCCAL VACCINATIONS RECEIVED BELOW)**:

MenACWY (AT LEAST 1 DOSE) ☐ Menveo* OR ☐ Menactra* OR ☐ MenQuadfi*

DATE OF FIRST DOSE RECEIVED (MM/DD/YYYY): _____ DATE OF SECOND DOSE RECEIVED (MM/DD/YYYY): _____

MenB (AT LEAST 1 DOSE) ☐ Bexsero** OR ☐ Trumenba** (3 DOSES REQUIRED)

DATE OF FIRST DOSE RECEIVED (MM/DD/YYYY): _____ DATE OF SECOND DOSE RECEIVED (MM/DD/YYYY): _____

DATE OF THIRD DOSE RECEIVED, IF APPLICABLE (MM/DD/YYYY): _____

C ☐ PATIENT NEEDS VACCINATION SUPPORT

YOU MAY USE THIS SECTION TO PROVIDE A PRESCRIPTION FOR VACCINES, OR YOU MAY PROVIDE A SEPARATE PRESCRIPTION. NEW YORK PRESCRIBERS MUST PROVIDE A SEPARATE PRESCRIPTION.

PRIMARY DIAGNOSIS DESCRIPTION: ENCOUNTER FOR IMMUNIZATION **ICD 10-CM CODE:** Z23

(PLEASE INDICATE WHICH VACCINES THE PATIENT NEEDS TO RECEIVE)

(NOTE: ALL VACCINES LISTED BELOW ARE ADMINISTERED INTRAMUSCULARLY AT A DOSE OF 0.5 mL)

Vaccines are not interchangeable. Patient must receive the same product for all doses.

MenACWY* ☐ MENVEO ☐ MENACTRA ☐ MENQUADFI

1ST DOSE: ON DAY 0 → 2ND DOSE: AT LEAST 8 WEEKS LATER

MenB BEXSERO** ☐

1ST DOSE: ON DAY 0 → 2ND DOSE: AT LEAST 1 MONTH LATER

MenB TRUMENBA** ☐

1ST DOSE: ON DAY 0 → 2ND DOSE: 1-2 MONTHS AFTER 1ST DOSE → 3RD DOSE: 6 MONTHS AFTER 1ST DOSE[a]

[a] For Trumenba, if dose 2 was administered at least 6 months after dose 1, dose 3 is not needed.

☐ OTHER: _____

***Three quadrivalent meningococcal conjugate (MenACWY) vaccines are currently licensed and available in the United States:**

1. Menactra (meningococcal groups A, C, W, and Y polysaccharide diphtheria toxoid conjugate vaccine (MenACWY-D))
2. Menveo (meningococcal groups A, C, W, and Y oligosaccharide diphtheria CRM conjugate vaccine (MenACWY-CRM))
3. MenQuadfi (meningococcal groups A, C, W, and Y polysaccharide tetanus toxoid conjugate vaccine (MenACWY-TT))

****Two serogroup B meningococcal (MenB) vaccines are licensed and available in the United States:**

1. Bexsero (MenB-4C)
2. Trumenba (MenB-FHbp)

Meningococcal vaccinations are indicated for adults, including people over 55 years of age, when on a complement inhibitor treatment.

FOR THE FULL VACCINE SCHEDULE, PLEASE REFER TO THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) VACCINE RECOMMENDATIONS OR TO ALEXION MEDICAL INFORMATION.

CPT codes: 907340 - Menveo, Menactra; 90619 - MenQuadfi; 90620 - Bexsero; 90621 - Trumenba; 90460 - vaccine administration

By signing below, I attest that: (i) based on my clinical judgment, the vaccines identified are medically necessary for the patient and diagnosis identified on this form; (ii) I am authorized under applicable law to prescribe the vaccines identified and I have verified and complied with all applicable prescription requirements; (iii) I am authorizing Alexion to forward the patient's prescription(s) to a pharmacy; (iv) I am under no obligation to prescribe the vaccines identified and I have not received, nor will I receive, any benefit from Alexion; and (v) the information provided on this form is complete, current, and accurate to the best of my knowledge.

SIGN HERE

Dispense As Written/Brand Medically Necessary/Do Not Substitute/ No Substitution/DAW/May Not Substitute

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

May Substitute/Product Substitute Permitted/Substitute Permissible

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

Please see Indications & Important Safety Information on page 6 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

US/SOL-g/0289 05/21

PRESCRIBER START FORM – NEUROLOGY

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

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial | ONESOURCE® Personalized Patient Support from Alexion

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	DATE OF BIRTH (MM/DD/YYYY)
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S PHONE NUMBER

STEP 8: SOLIRIS PRESCRIPTION ORDER (OPTIONAL)

YOU MAY USE THIS SECTION TO PROVIDE A PRESCRIPTION FOR SOLIRIS, OR YOU MAY PROVIDE A SEPARATE PRESCRIPTION. NEW YORK PRESCRIBERS MUST PROVIDE A SEPARATE PRESCRIPTION.

☐ SOLIRIS® (eculizumab) NDC # 25682-0001-01/HCPCS CODE: J1300 PER UNIT ICD 10-CM MG (G70.00)/NMOSD (G36.0)

WEEKS 1 THROUGH 4 (RECOMMENDED DOSE 900 MG WEEKLY FOR FIRST 4 WEEKS):

☐ _____ 300-MG SINGLE-DOSE SOLIRIS VIALS (12 RECOMMENDED)

☐ OTHER: DISPENSE _____ 300-MG SINGLE-DOSE SOLIRIS VIALS

INFUSION INSTRUCTIONS:

WEEK 5 (RECOMMENDED DOSE 1200 MG 1 WEEK AFTER PREVIOUS DOSE):

☐ _____ 300-MG SINGLE-DOSE SOLIRIS VIALS (4 RECOMMENDED)

☐ OTHER: DISPENSE _____ 300-MG SINGLE-DOSE SOLIRIS VIALS

INFUSION INSTRUCTIONS:

MAINTENANCE TREATMENT (RECOMMENDED DOSE 1200 MG EVERY 2 WEEKS): ☐ DISPENSE _____ 300-MG SINGLE-DOSE SOLIRIS VIALS

INSTRUCTIONS /DIRECTIONS:

STEP 9: PRESCRIBER CERTIFICATION

By signing below, I attest that: (i) based on my clinical judgment, SOLIRIS is medically necessary for the patient and diagnosis identified on this form and I will be supervising the patient's treatment; (ii) I am authorized under applicable law to prescribe SOLIRIS 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; (iv) I am under no obligation to prescribe SOLIRIS and I have not received, nor will I receive, any benefit from Alexion for prescribing SOLIRIS; and (v) the information provided on this form is complete, current, and accurate to the best of my knowledge. I also acknowledge that Alexion will use and share the personal data collected about me (as the prescriber) in accordance with the Privacy Notice on the Alexion website at https://alexion.com/Legal#privacy.

SIGN HERE

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

INDICATIONS & IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab)

INDICATIONS
What is SOLIRIS?

SOLIRIS is a prescription medicine used to treat:

- adults with a disease called generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive.
- adults with a disease called neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive.

It is not known if SOLIRIS is safe and effective in children with gMG or NMOSD.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about SOLIRIS?

SOLIRIS is a medicine that affects your immune system and can lower the ability of your immune system to fight infections.

- **SOLIRIS increases your chance of getting serious and life-threatening meningococcal infections that may quickly become life-threatening and cause death if not recognized and treated early.**

1. You must receive meningococcal vaccines at least 2 weeks before your first dose of SOLIRIS if you are not vaccinated.
2. If your doctor decided that urgent treatment with SOLIRIS is needed, you should receive meningococcal vaccination as soon as possible.
3. If you have not been vaccinated and SOLIRIS therapy must be initiated immediately, you should also receive two weeks of antibiotics with your vaccinations.
4. If you had a meningococcal vaccine in the past, you might need additional vaccination. Your doctor will decide if you need additional vaccination.
5. Meningococcal vaccines reduce but do not prevent all meningococcal infections. Call your doctor or get emergency medical care right away if you get any of these signs and symptoms of a meningococcal infection: headache with nausea or vomiting, headache and fever, headache with a stiff neck or stiff back, fever, fever and a rash, confusion, muscle aches with flu-like symptoms, and eyes sensitive to light.

Your doctor will give you a Patient Safety Card about the risk of meningococcal infection. Carry it with you at all times during treatment and for 3 months after your last SOLIRIS dose. It is important to show this card to any doctor or nurse to help them diagnose and treat you quickly.

SOLIRIS is only available through a program called the SOLIRIS REMS. Before you can receive SOLIRIS, your doctor must enroll in the SOLIRIS REMS program; counsel you about the risk of meningococcal infection; give you information and a **Patient Safety Card** about the symptoms and your risk of meningococcal infection (as discussed above); and make sure that you are vaccinated with the meningococcal vaccine and, if needed, get revaccinated with the meningococcal vaccine. Ask your doctor if you are not sure if you need to be revaccinated.

SOLIRIS may also increase the risk of other types of serious infections. Certain people may be at risk of serious infections with gonorrhea. Certain fungal infections (*Aspergillus*) may occur if you take SOLIRIS and have a weak immune system or a low white blood cell count.

Who should not receive SOLIRIS?

Do not receive SOLIRIS if you have a meningococcal infection or have not been vaccinated against meningitis infection unless your doctor decides that urgent treatment with SOLIRIS is needed.

Before you receive SOLIRIS, tell your doctor about all of your medical conditions, including if you: have an infection or fever, are pregnant or plan to become pregnant, and are breastfeeding or plan to breastfeed. It is not known if SOLIRIS will harm your unborn baby or if it passes into your breast milk.

Tell your doctor about all the vaccines you receive and medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements which could affect your treatment. It is important that you have all recommended vaccinations before you start SOLIRIS, receive 2 weeks of antibiotics if you immediately start SOLIRIS, and stay up-to-date with all recommended vaccinations during treatment with SOLIRIS.

What are the possible side effects of SOLIRIS?

SOLIRIS can cause serious side effects including serious infusion-related reactions. Tell your doctor or nurse right away if you get any of these symptoms during your SOLIRIS infusion: chest pain, trouble breathing or shortness of breath, swelling of your face, tongue, or throat, and feel faint or pass out. If you have an infusion-related reaction to SOLIRIS, your doctor may need to infuse SOLIRIS more slowly, or stop SOLIRIS.

The most common side effects in people with gMG treated with SOLIRIS include: muscle and joint (musculoskeletal) pain.

The most common side effects in people with NMOSD treated with SOLIRIS include: common cold (upper respiratory infection), pain or swelling of your nose or throat (nasopharyngitis), diarrhea, back pain, dizziness, flu like symptoms (influenza) including fever, headache, tiredness, cough, sore throat, and body aches, joint pain (arthralgia), throat irritation (pharyngitis), and bruising (contusion).

Tell your doctor about any side effect that bothers you or that does not go away. These are not all the possible side effects of SOLIRIS. For more information, ask your doctor or pharmacist. Call your doctor for medical advice about side effects. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit MedWatch, or call 1-800-FDA-1088.

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

SOLIRIS PRESCRIBER START FORM – A HOW-TO GUIDE

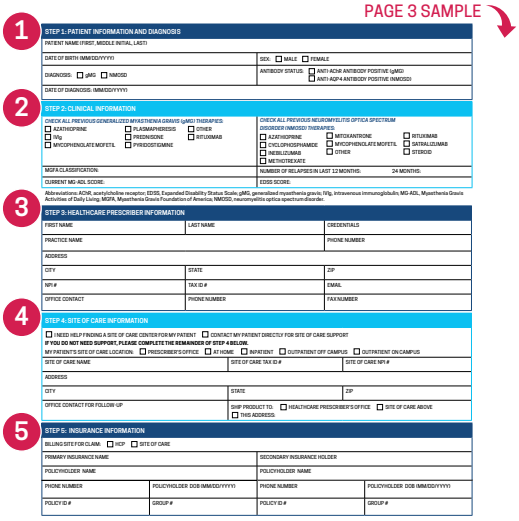
FAX: 1.800.420.5150
MAIL: 100 College St., New Haven, CT 06510
EMAIL: OneSource@Alexion.com
PHONE: 1.888.765.4747
8:30 AM to 8 PM ET Monday-Friday

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial | ONESOURCE® Personalized Patient Support from Alexion

PRESCRIBER: Use these tips as guidelines to help complete the **PRESCRIBER START FORM**. By completing the form, you can initiate a prescription of SOLIRIS for your patients.

NOTE: Your patient also needs to sign **PAGE 1** of the **PATIENT START FORM**. Upon completion, fax or email **PAGES 1, 3, 4, and 5** to OneSource™. Remember to also send OneSource™ copies of your patient's medical insurance and pharmacy coverage cards.

PAGE 3 SAMPLE



STEPS 1 & 2

Fill out relevant information about your patient and their diagnosis. Do your best to fill out these fields, especially the one related to antibody status.

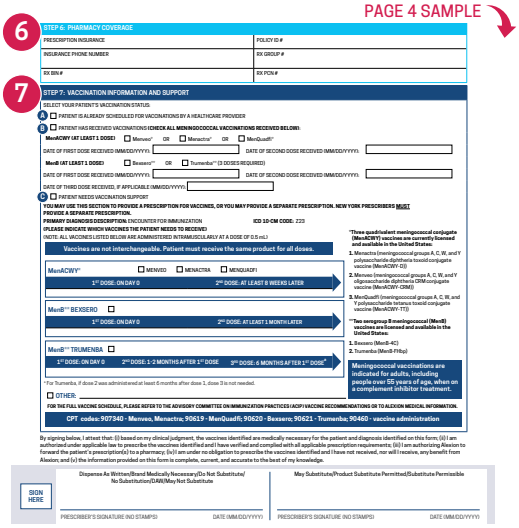
STEP 3

The information in this section is essential to complete, as it requires prescriber details. Any delays in getting this information may delay the start of treatment.

STEPS 4 & 5

Provide information about the planned site of care for your patient, as well as their insurance information.

PAGE 4 SAMPLE



STEP 6

Some patients have additional pharmacy benefits. If your patient has this type of coverage, please add those details here.

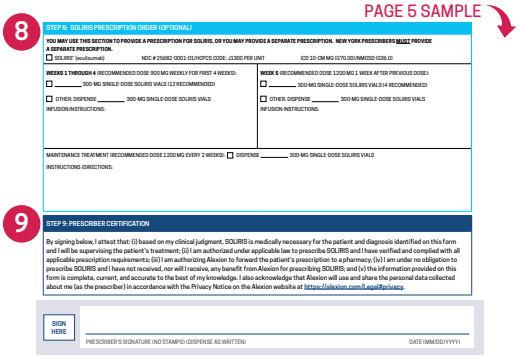
Remember to send OneSource™ copies of the front and back of their insurance and pharmacy coverage cards.

STEP 7

Choose one of the three options offered to your patient, A, B, or C. Depending on your selection and your patient's insurance coverage, OneSource™ may be able to assist your patient.

NOTE: **Option C** can serve as the prescription for the vaccinations. **New York prescribers must provide a separate prescription.**

PAGE 5 SAMPLE



STEP 8

This optional step of the form is the SOLIRIS prescription. You may use this part of the form to provide a prescription for SOLIRIS, or you may include a separate prescription when you send the PRESCRIBER START FORM to OneSource™.

NOTE: **New York prescribers must provide a separate prescription.**

STEP 9

The prescriber's signature is required to attest that the information provided on this form is complete, current, and accurate based on current knowledge.

Contact OneSource™ if you have any questions while completing the forms.

Please return pages 1, 3, 4, and 5 to OneSource™.

Please see Indications & Important Safety Information on page 6 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

US/SOL-g/0289 05/21

FOR PATIENTS: TAKE THIS PAGE HOME TO REFER BACK TO WHEN NEEDED.

ONESOURCE™: WE'RE HERE TO HELP.

WHAT YOU CAN EXPECT

Once we receive your PATIENT START FORM, OneSource™ will call you in 1-2 business days to discuss:

- Health insurance navigation
- Vaccination support
- Infusion location
- Additional support based on your questions

VISIT: AlexionOneSource.com **CALL:** 1.888.765.4747 **EMAIL:** OneSource@Alexion.com

ADD ONESOURCE™ TO YOUR CONTACTS:

Go to your camera on your mobile device

Scan the QR code on the left

The OneSource™ number, 1.888.765.4747, will be automatically added to your contact list so you'll recognize the caller.

OneSource™ is a complimentary, personalized patient support program offered by Alexion. It's designed to support your specific needs throughout treatment. When you fill out and sign the **PATIENT START FORM**, OneSource™ will reach out to help you get started.

Once you're enrolled, OneSource™ experts can support you with:

DISEASE INFORMATION
Educational materials and resources related to your diagnosis.

ONGOING SUPPORT
Support to help you follow the care plan from your physician.

HEALTH INSURANCE NAVIGATION
Options to help you access treatment, no matter your insurance coverage.

COMMUNITY CONNECTIONS
Information about patient meetings, events, and advocacy groups.

SOLIRIS® (eculizumab) Injection for Intravenous Use 300 mg/30 mL vial | ONESOURCE® Personalized Patient Support from Alexion

Please see Indications & Important Safety Information on page 6 and full Prescribing Information and Medication Guide for SOLIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections, also available on www.SOLIRIS.net.

US/SOL-g/0289 05/21