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™ is a complimentary, personalized patient support program offered by Alexion. It's designed to support patients' specific needs throughout treatment. For more information, visit www.AlexionOneSource.com.

INSTRUCTIONS FOR PATIENTS: To enroll in OneSource, please follow these steps:

1. Complete all the required information (in red) on **PAGE 1** and read the Authorization to Share Health Information on **PAGE 2**
2. Sign the Authorization to Share Health Information section on **PAGE 1**
3. Email or fax **PAGE 1 of the form** and **copies of the front and back of your insurance and pharmacy coverage cards** to OneSource. See the email address and fax number above

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 submit this form fully and correctly completed.

Note: You can choose not to sign this form. However, we cannot provide personalized support without your signed authorization.

Fields in red are required.

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

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 A TEXT MESSAGE? ☐ YES ☐ NO OK TO LEAVE A PHONE MESSAGE? ☐ YES ☐ NO	
PATIENT DIAGNOSIS		
PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER ____________	PATIENT EMAIL ☐ NONE	
LEGAL PATIENT REPRESENTATIVE NAME: PHONE: RELATIONSHIP TO PATIENT EMAIL:	DESIGNATED PATIENT REPRESENTATIVE 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 next page.

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

CONSENT FOR PROMOTIONAL COMMUNICATIONS (OPTIONAL)

INITIAL FOR CONSENT

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.

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.

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 on the next page.

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

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, or 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 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 vaccine services;
- access my credit information and information from other sources to estimate my income, if needed to assess eligibility for financial assistance programs;
- remove identifiers from My Information and combine such resulting information with other information for research, regulatory submissions, business improvement projects, and publication purposes; and
- contact me about market research or clinical studies.

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, 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.

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.

Copay Program Eligibility
By participating in the Alexion OneSource CoPay Program, participants acknowledge that they understand and agree with the complete program terms and conditions available at https://alexiononesource.com/CoPay or on request by contacting OneSource at 1.888.765.4747.

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