OneSource™ Enrollment and Authorization Form

Alexion Pharmaceuticals, Inc.
100 College St
New Haven, CT 06510

Patient Information (Please check off appropriate Indication)

- ☐ Patient with atypical hemolytic uremic syndrome (aHUS)
- ☐ Patient with generalized myasthenia gravis (gMG)
- ☐ Patient with hypophosphatasia (HPP)
- ☐ Patient with lysosomal acid lipase deficiency (LAL-D)
- ☐ Patient with neuromyelitis optica spectrum disorder (NMOSD)
- ☐ Patient with paroxysmal nocturnal hemoglobinuria (PNH)

First name: _____ Last name: _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Date of birth: ___ ___ ___ Gender: _____

Telephone number(s) of Patient (or Designated Representative, if applicable): _____

Email of Patient (or Designated Representative) (optional): _____

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: _____

Additional Permissions (optional)

Name: _____ Relationship to Patient: _____

Phone: _____ Cell phone: _____ Email: _____

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 also 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 digits 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 productlines;
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.

Signature

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.

Signature of patient/legally authorized person: _____

Date signed: _____

Sign below if you wish to receive Alexion communications: 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.

Signature of patient/legally authorized person: _____

Date signed: _____

Alexion OneSource Contact Information

Email: OneSource@Alexion.com **Phone:** 1-888-765-4747 **Fax:** 1-800-420-5150

ONESOURCE® Personalized Patient Support from Alexion