PATIENT SERVICES CONSENT

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

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™.

Patient indication: _____

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)

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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.

ALEXION®