

OneSource is available to provide essential support, regardless of the management plan you and your physician choose. OneSource is a complimentary program offered by Alexion that is staffed by nurse case managers, who are registered nurses with clinical knowledge and funding expertise.

OneSource nurse case managers provide ongoing support in the following areas:

- **Education:** Collaborating with your healthcare team to answer questions and provide educational materials related to your disease
- **Coverage issues and funding options:** Assisting patients and practices with insurance coverage questions and research funding options
- **Management support:** Assisting with solutions for balancing all aspects of disease management when faced with major life challenges

In order to participate in OneSource and receive these patient services, OneSource needs to receive, use, and share your personal health information. In this Form, we are asking you to agree to let your healthcare providers, health plan, or health insurers release your health information (sometimes called "Protected Health Information" or "PHI") to OneSource and to allow OneSource and its agents to use and share your PHI.

The PHI we need includes medical records regarding your medical condition and treatment, information about how well you are able to manage your treatment plan, information about your insurance coverage and benefits, and identifying information about you (including your name, address, date of birth, and Social Security number). OneSource will only use this PHI in the ways described in this Form or as otherwise permitted by law.

You do not have to sign this Form and, if you choose not to sign it, your ability to obtain treatment from your healthcare providers and your eligibility for benefits under your health plan will not be affected. However, if you do not sign this Form, OneSource may not be able to provide you with the services listed above.

To enroll in the OneSource program for personalized support, please read the information on the back page and fill out, sign, and date the Form. Please read this Form carefully and contact OneSource if you have any questions.

# OneSource™ Enrollment and Authorization Form

## Patient Information (Please check off appropriate Indication)

- Patient with paroxysmal nocturnal hemoglobinuria (PNH)     Patient with atypical hemolytic uremic syndrome (aHUS)     Patient with hypophosphatasia (HPP)     Patient with lysosomal acid lipase deficiency (LAL-D)

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 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, sub-contractors, agents, and other representatives (together, "Alexion") to provide me with patient support services related to any of Alexion's products including, but not limited to, online support, financial assistance services, compliance and persistency services, and other therapy support services, as well as any information or materials related to such 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 providing medical treatment or advice.

## Authorization to Use and Disclose Protected Health Information

I (or my representative) agree to permit the **Authorized Parties** listed below to disclose my Protected Health Information ("PHI") to Alexion Pharmaceuticals, Inc. for the uses described below.

### The Authorized Parties include:

- (1) My primary care physician, evaluating and/or treating physician, and any specialist or other healthcare providers involved in my treatment ("Providers");
- (2) the distributor, pharmacy, or home health agency that dispenses my medical therapy ("Distributors"); and
- (3) my health insurer, payor, or patient assistance program ("Payors").

The PHI that may be disclosed includes medical reports, orders, prescriptions and records, histories, findings, prognoses, plans of care and discharge summaries, billing information, insurance claims, and utilization review reports.

The **Authorized Parties** may disclose my PHI to Alexion, so that Alexion may use and disclose the PHI for the following purposes:

- 1. Coordination of care:** Between me, the Providers, Distributors, or Payors 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, Payors, and Distributors.
- 3. Clinical research/treatment protocols:** To inform me (or my representative) of clinical research studies, treatment protocols, or disease-related surveys that may benefit me.
- 4. Reviewing insurance benefits/plan and/or funding options:** To review, co-verify, and to assist me (or my representative) in understanding the benefits provided by my Payor, to verify what services my 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, if necessary.
- 5. Billing and payment:** To coordinate the preparation, filing, and processing

of health insurance claims, the evaluation of coding (billing) issues, and assist 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. Other uses of PHI:** To de-identify the information about me and to use this de-identified information in performing research, patient and community education, clinical protocol development, marketing studies, or for other commercial purposes as determined by Alexion.

**10. 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.

## Notice

I (or my representative) understand that once my PHI has been disclosed to Alexion, federal privacy laws may no longer protect it from further disclosure. However, Alexion agrees to protect my PHI by using and disclosing it only for the purposes described in this Authorization 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, 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, Alexion may not be able to provide the services described above.

## Signature

I (or my representative) have read and understand the terms of 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 by sending a written letter which includes my name and address, to Alexion Pharmaceuticals, Inc. at the address or fax on the top of this form. I (or my representative) have the right to receive a copy of this Authorization upon request.

**X**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient or Designated Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Fax completed forms to: 1-800-420-5150**

**Alexion OneSource Contact Information**

**Phone: 1-888-765-4747**

**Fax: 1-800-420-5150**