OneSource™ Enrollment Form

To enroll in the OneSource program for personalized support, please read the information below. Fill out, sign, and date all appropriate sections.

PHONE: 1-888-765-4747
PATIENTS WITH HPP FAX: 1-844-328-5876
PATIENTS WITH LAL-D FAX: 1-800-420-5150

PATIENT INFORMATION

☐ 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:**

SECTION A

Authorization to Use and Disclose Protected Health Information

By signing this Authorization, you agree to permit the **Authorized Parties** listed below to disclose Protected Health Information (PHI) about you to Alexion Pharmaceuticals, Inc. for the uses described more fully below.

The Authorized Parties include:

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

The PHI ("Information") 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 this Information to Alexion Pharmaceuticals Corporation, including, but not limited to, its employees, sub-contractors, agents, and other representatives (together, "Alexion"), so that Alexion may use and disclose the Information for the following purposes:

1. Coordination of Care: Between you, the Providers, Distributors, or Payors for the coordination of your medical care.

2. Disease Management/Patient Education: To provide information, training, and case management services to you (or your representative), and any Providers, Payors, and Distributors.

3. Clinical Research/Treatment Protocols: To inform you (or your representative) of clinical research studies, treatment protocols, or disease-related surveys that may benefit you.

4. Reviewing Your Insurance Benefits/Plan and/or Funding Options: To review, verify, and to assist you in understanding the benefits provided by your Payor, to verify what services your benefits cover and help you obtain the services ordered by your 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 your therapy.

6. Distribution of Hematologic Therapy: To coordinate the distribution of medical therapy to you.

7. Product Orders: To fulfill any product orders and answer any questions that you may provide to the Alexion call center, and otherwise to inform you about other services that may be of interest to you.

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 Use of Information: To de-identify the information about you and to use this de-identified information in performing clinical research, patient and community education, clinical protocol development, marketing studies, or for other commercial purposes as determined by Alexion.

10. Contact: To contact you or your authorized representative (if designated above) by mail, e-mail, or telephone. Once your Information has been disclosed to Alexion, federal privacy laws may no longer protect it from further disclosure. However, Alexion agrees to protect your Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. You do not have to sign this Authorization. If you do not sign this Authorization, or choose to revoke it, your ability to obtain medical care and/or therapy, or your eligibility or enrollment for insurance benefits will not be affected. However, if you do not sign this Authorization, Alexion will not be able to provide the services described above.

This Authorization shall remain in effect for ten (10) years unless it is revoked (taken back) by you. You may revoke this Authorization at any time by sending a written letter which includes your name and address, to Alexion Pharmaceuticals, Inc. at the address or fax on the top of this form. You have the right to receive a copy of this Authorization upon request.

SECTION B

Patient Services/Other Communications Authorization

Support by OneSource patient support program

I authorize Alexion Pharmaceuticals, and companies working with Alexion Pharmaceuticals, to provide me with 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 agree and acknowledge that any Alexion personnel providing such support services are not employed by my healthcare professional. I authorize Alexion, and companies working with Alexion, to contact me to provide such services and information 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. I also authorize Alexion, and companies working with Alexion, to use my health information in connection with the services, including, without limitation, sharing such information with my healthcare provider, insurance provider, or pharmacy. I also authorize the disclosure of my health information to specific individuals that I have designated.

Marketing/Other Communications

I further authorize Alexion Pharmaceuticals, and companies working with Alexion Pharmaceuticals, to contact me by mail, email, fax, telephone call, and text message for marketing purposes or otherwise provide me with information about Alexion's products, services, and programs or other topics of interest, conduct market research, or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Alexion to help develop new products, services, and programs. (Note that Alexion will not sell or transfer your personal data to any unrelated third party for marketing purposes without your express permission.) I understand that I may revoke this authorization and choose not to receive services or information from Alexion by mailing a letter to OneSource at 352 Knotter Drive, Cheshire, CT 06410.

SECTION C

☑ I have read and understand **SECTION A** – Authorization to Use and Disclose Protected Health Information and agree to the terms.

☐ I have read and understand **SECTION B** – Patient Services/Other Communications Authorization and agree to the terms.

Signature of Patient or Designated Representative ____/____/____ Date

FAX COMPLETED FORMS TO:
1-844-328-5876 (PATIENTS WITH HPP)
1-800-420-5150 (PATIENTS WITH LAL-D)

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ONESOURCE™ TREATMENT SUPPORT