

Instructions

ULTOMIRIS is only available through a restricted program called the ULTOMIRIS REMS (Risk Evaluation and Mitigation Strategy). All prescribers must be specially certified. To become certified, prescribers must:

- 1) **Review** the ULTOMIRIS Prescribing Information, Prescriber Safety Brochure, Patient Safety Brochure and the Patient Safety Card.
- 2) **Enroll** in the ULTOMIRIS REMS by completing this form.
- 3) **Counsel** patients and provide them with the Patient Safety Brochure and Patient Safety Card.

You may complete this form

- online at www.ultomirisrems.com
- by fax at 1-877-580-2596 (ALXN)
- by scanning and emailing to REMS@alexion.com
- by mailing to Alexion Pharmaceutical, Inc. ATTN: REMS Program, 121 Seaport Boulevard, Boston, MA 02210

Prescriber Responsibilities

By completing, signing and submitting this form, I acknowledge and agree that:

- I have read and understand the ULTOMIRIS Prescribing Information (PI), *Prescriber Safety Brochure*, *Patient Safety Brochure*, and the *Patient Safety Card*.
- I understand the:
 - o risk of meningococcal infections associated with ULTOMIRIS.
 - o early signs of meningococcal infections
 - o need for immediate medical evaluation of signs and symptoms with possible meningococcal infections
- Before treatment initiation at least 2 weeks prior to the first dose, I will:
 - o Assess the patient's meningococcal vaccine status and immunize patients unless the risks of delaying ULTOMIRIS therapy outweigh the risks of developing meningococcal infection.
 - o Provide the patient with a prescription for a two-week course of antibiotic prophylaxis if ULTOMIRIS must be started right away.
 - o Counsel the patient about the signs and symptoms of meningococcal infections using the *Patient Safety Card*, and *Patient Safety Brochure*. Provide a copy of these materials to the patient. Instruct the patient to carry the *Patient Safety Card* at all times.
- During treatment, I will:
 - o Assess the patient for early signs of meningococcal infection and evaluate immediately if infection is suspected.
 - o Consider discontinuation of ULTOMIRIS in patients who are undergoing treatment for serious meningococcal infections.
 - o Revaccinate patients according to the Advisory Committee on Immunization Practices recommendations.
- I will report cases of meningococcal infection including the patient's clinical outcomes to Alexion Pharmaceuticals, Inc.
- I understand that if I do not maintain compliance with the requirements of the ULTOMIRIS REMS, I will no longer be able to prescribe ULTOMIRIS.
- I understand that ULTOMIRIS REMS and its agents or contractors may contact me to support the administration of the ULTOMIRIS REMS.

Prescriber Information (All Fields Required Unless Otherwise Indicated)

First Name:	MI (opt):	Last Name:
NPI:	Email:	
Clinic/Practice Name:		
Address:		
City:	State:	Zip Code:
Phone (Ext opt):	Fax:	
Credentials: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN* <input type="checkbox"/> PA <input type="checkbox"/> Other (please specify):		
Medical Specialty (please select one): <input type="checkbox"/> Hematology/Oncology <input type="checkbox"/> Immunology <input type="checkbox"/> Internal medicine <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology		
<input type="checkbox"/> Rheumatology <input type="checkbox"/> Other (please specify):		
Prescriber's Signature: _____		Date (MM/DD/YYYY): _____

*Includes Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse-Midwife (CNM).

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