CERTIFICATE : vaccination and/or prophylactic antibiotics

This form must be completed and provided to Alexion before initiation of therapy with

SOLIRIS® (Eculizumab) 300 mg, Concentrate of Solution for Infusion

This is <u>mandatory</u> before any shipment can be made.

TO BE IMMEDIATELY TRANSMITTED VIA FAX OR AS A SCANNED PDF VIA EMAIL

To: ALEXION **Page 1 of** _____

Fax / Email: 044 457 45 04 or German.Orders@alexion.com **Date:** _____ *(dd/mmm/yyyy)*

Name of Prescriber:		
Hospital:		**Phone Number:**
Address:		**Fax Number:**
City:	**Country:**	**Email:**
Information on Patient:	Birth Date: _____*(dd/mmm/yyy)*	

Indication: ☐ **PNH** ☐ **aHUS** ☐ ***Other*** _____*(specify) (optional)*

The patient is/is to be included in the reimbursement registry: ☐ **Yes** ☐ **No**

Commitment

I, the undersigned, _____ , hereby undertake to ensure or confirm that:

I must explain *Soliris* treatment to the patient/parent(s)/legal guardian(s) and I must deliver to the patient/parent(s)/legal guardian(s) all necessary information, including the "Patient Safety Card" and relevant educational materials before initiating Soliris treatment.

☐ I am requesting specified educational materials and commit to provide these materials to this patient.

The Patient *(Check as Appropriate):*

Received a vaccination against meningococcal infection, preferably against serotypes A, B, C, Y, W 135 and B:

☐ At least 2 weeks prior to administration of the 1st dose of *Soliris*.

☐ Less than 2 weeks prior to administration of the 1st dose of *Soliris*.

The patient therefore receives prophylactic antibiotics from at least the 1st day of *Soliris* treatment and until 2 weeks after the vaccination against meningococcal infection.

Vaccination date is (*dd/mmm/yyyy*) _____ ***Vaccine(s)***_____ *(optional)*

☐ Receives/will receive prophylactic antibiotics from at least the 1st day of *Soliris* treatment and during the entire treatment period because the vaccine is contra-indicated for the patient.

☐ Receives/will receive prophylactic antibiotics from at least the 1st day of *Soliris* treatment until 2 weeks after the patient can be vaccinated (e.g., young children or when vaccination may further activate complement and may increase the signs and symptoms of the underlying complement-mediated disease).

Sincerely, **Date :**

Signature: _____ _____ *(dd-mmm-yyyy)*

FOR ALEXION USE ONLY

Patient Code: _____ will be completed by Alexion.

After the patient is validated by Alexion, a patient code will be allocated by Alexion. The patient code and patient birth date will need to be provided for any further orders.