CERTIFICATE: Vaccination and/or Prophylactic Antibiotics

This form must be completed and provided to Alexion before initiation of therapy with SOLIRIS® (eculizumab) or ULTOMIRIS® (ravulizumab) (as requested by European Medicines Agency)

This is **mandatory** before any shipment can be made.

To Be Immediately Transmitted via Fax or as a Scanned PDF VIA E-MAIL

+353 1 254 64 07 or CustomerOperationsEU@alexion.com

To: ALEXION	Fax / Email:		Page 1 of	

Name of Prescriber:		
Hospital:		**Phone Number:**
Address:		**Fax Number:**
City:	**Country:**	**Email:**

Information on Product and Indication

The patient will be treated with:

☐ **SOLIRIS®** *(eculizumab)*	**Indication**	☐ PNH ☐ aHUS ☐ NMOSD ☐ Refractory gMG	Other: (specify) (optional)	
☐ **ULTOMIRIS®** *(ravulizumab)*	**Indication**	☐ PNH ☐ aHUS	Other: (specify) (optional)	

Information on Patient

Birth Date (*DD/MM/YYYY*)		The patient is/is to be included in the disease registry: ☐ **Yes** ☐ **No**

Commitment

I, the undersigned, _____ , hereby undertake to ensure or confirm that:
I must explain the complement inhibitor 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 the complement inhibitor 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:

☐ At least 2 weeks prior to administration of the 1st dose of the complement inhibitor treatment.

☐ Less than 2 weeks prior to administration of the 1st dose of the complement inhibitor treatment.

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

Vaccination date (*DD/MMM/YYYY):* _____ **Vaccine(s)** (optional): _____

Date of initiation of antibiotherapy (*DD/MMM/YYYY) (If known)* _____

☐ Receives/will receive prophylactic antibiotics from at least the 1st day of the complement inhibitor 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 the complement inhibitor 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,

Signature:	**Date:** (*DD/MMM/YYYY):*

FOR ALEXION USE ONLY

SAP Reference Code: _____ will be completed by Alexion.

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