SOLIRIS® (eculizumab) Injection for Intravenous Use

SOLIRIS REMS Program

# Prescriber Enrollment Form

Fax: 1-877-580-2596
www.solirisrems.com

## Instructions

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

1) **Review** the SOLIRIS Prescribing Information, Prescriber Safety Brochure, Patient Safety Brochure and the Patient Safety Card.
2) **Enroll** in the SOLIRIS 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.solirisrems.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 SOLIRIS Prescribing Information (PI), *Prescriber Safety Brochure*, *Patient Safety Brochure,* and the *Patient Safety Card.*
- I understand the:
  - risk of meningococcal infections associated with SOLIRIS.
  - early signs of meningococcal infections
  - 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:
  - Assess the patient's meningococcal vaccine status and immunize patients unless the risks of delaying Soliris therapy outweigh the risks of developing meningococcal infection.
  - Provide the patient with a prescription for a two-week course of antibiotic prophylaxis if Soliris must be started right away.
  - 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:
  - Assess the patient for early signs of meningococcal infection and evaluate immediately if infection is suspected.
  - Discontinue SOLIRIS in patients who are being treated for serious meningococcal infections.
  - 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 SOLIRIS REMS, I will no longer be able to prescribe SOLIRIS.
- I understand that SOLIRIS REMS and its agents or contractors may contact me to support the administration of the SOLIRIS 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: ☐ MD ☐ DO ☐ APRN* ☐ PA

Medical Specialty (please select one): ☐ Hematology/Oncology ☐ Immunology ☐ Internal medicine ☐ Nephrology ☐ Neurology ☐ Rheumatology ☐ 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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