MyALPROLIX™ | RESOURCES. SOLUTIONS. ANSWERS.

Enrollment Form

For Copay, Factor Access, and Insurance Counseling Programs

MyALPROLIX is a resource that provides personalized service to patients and healthcare providers. Through MyALPROLIX, patients may be eligible to receive assistance through our support services, such as our **Copay Program**, **Factor Access Program**, and **Insurance Counseling**. Patients and healthcare providers will have access to a MyALPROLIX Coordinator, who will work with them directly, tailoring resources to each patient's specific needs.

Complete and return the enrollment form on **page 3** to access information, support, and resources for **ALPROLIX® [Coagulation Factor IX (Recombinant), Fc Fusion Protein]**.

Print and fax completed enrollment form to 1-855-398-7634.

Instructions for Patients

- **Page 2:** Carefully read the HIPAA Authorization to Share Health Information, Patient Services Authorization, and the optional Opt-In to Receive Marketing Communications. This information is associated with **sections** A, B, and C of the enrollment form
- **Page 3:** Sign the yellow highlighted areas in **sections** A and B. You can sign via eSignature or print and sign. Fill out **sections** C (if desired), D, and E with your information and **section** F with information about your healthcare provider
- Print and fax the completed form to **1-855-398-7634**

Instructions for Healthcare Providers

- **Page 2:** Make sure your patient has reviewed the HIPAA Authorization to Share Health Information, Patient Services Authorization, and the optional Opt-In to Receive Marketing Communications. This information is associated with **sections** A, B, and C of the enrollment form
- **Page 3:** Make sure your patient has signed the yellow highlighted areas in **sections** A and B, whether via eSignature or written signature. Fill out **sections** C (if patient chooses to opt-in), D, and E with your patient's information (if the patient has not already) and **section** F with your information. Don't forget to check the box if you want the results of your patient's benefits investigation and eligibility for MyALPROLIX programs
- Fax the completed form to **1-855-398-7634**

Please see full Indications and Important Safety Information on page 4, and full Prescribing Information. This is an electronic PDF from ALPROLIX.com.

? Call 1-855-MyALPROLIX (692-5776) Monday through Friday 8 AM to 8 PM, ET to speak with a MyALPROLIX Coordinator.

Biogen

ALPROLIX® [Coagulation Factor IX (Recombinant), Fc Fusion Protein]

A HIPAA Authorization to Share Health Information

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy or other institutional healthcare providers to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), health information relating to my medical condition, treatment, and insurance coverage that is needed to provide me with various services such as online support, and financial and reimbursement services. I also authorize the disclosure of my health information to specific individuals I have designated below. Once my health information has been disclosed to Biogen and/or such other individuals, I understand that federal privacy laws may no longer protect the information. However, Biogen agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Biogen in exchange for the health information and/or for any therapy support services provided to me.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with a Biogen product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization.

I may cancel this Authorization at any time by mailing a letter to: Biogen, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709 or visiting biogen.com/privacy. Canceling this Authorization will end my consent to further disclosure of my health information to Biogen, and my receipt from Biogen of therapy support services, after the date Biogen receives my letter, but will not affect my healthcare providers' or Biogen's ability to use and disclose health information that it has already disclosed or received before receipt of my letter. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires ten (10) years from the day it is given as indicated by the date to the right, unless canceled as set forth above. I understand I may receive a copy of the signed authorization if requested.

Please sign in the space in section A on the next page.

B Patient Services Authorization

I further authorize Biogen to provide me with various therapy support services, including but not limited to: online support, financial assistance services, reimbursement services, and compliance and persistency services, as well as any information or materials related to such services. I also authorize Biogen to contact me to ask me about my experience with or thoughts about products, services, and programs that Biogen offers or sponsors. I understand and agree that any information I provide may be used by Biogen to help develop new products, services, and programs. I understand and agree that Biogen may contact me about such services and information by mail, e-mail, telephone call, fax, or text message (including autodialed or prerecorded calls), or other means at the telephone numbers, e-mail, and mailing addresses I provide. I also authorize Biogen 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 understand that I may refuse to sign this Authorization and choose not to receive information or services from Biogen. I further understand my treatment (including with a Biogen product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. I may cancel this Authorization at any time by mailing a letter to: Biogen, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709 or visiting biogen.com/privacy.

Please sign in the space in section B on the next page.

C Opt-In to Receive Marketing Communications (optional)

MyALPROLIX would like to send you additional information about ALPROLIX and financial assistance programs.

You must be thirteen (13) years or older to enroll. If you are aged 13 to 18, you should get your parent's or guardian's permission before providing your personal health information. We will not sell or transfer your Personal Data to any unrelated third party for marketing purposes without your express permission. We may also share such Personal Data with regulatory authorities, if required, or contact you to conduct market research.

I authorize Biogen, and companies working with Biogen, to contact me by mail, e-mail, fax, and/or telephone, including calls and text messages made using an automatic telephone dialing system or a prerecorded voice at the telephone number(s) provided to provide me with the information I requested and other related information and services or programs that Biogen offers or sponsors, or other topics of interest.
I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Biogen.

To learn more about how your personal information is used or if you decide that you no longer want to receive information about Biogen's products and services, please visit biogen.com/privacy.

Please check the box in section C on the next page if you'd like to opt-in.

Please see full Indications and Important Safety Information on page 4, and full Prescribing Information.
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Enrollment Form

Fax completed enrollment form to 1-855-398-7634.

PLEASE BE SURE TO COMPLETE THIS FORM IN ITS ENTIRETY AND SIGN THE HIGHLIGHTED AREAS TO ENSURE YOUR APPLICATION IS PROCESSED IN A TIMELY MANNER

SECTIONS A–E: COMPLETE THE INFORMATION BELOW

A HIPAA Authorization to Share Health Information

I have read and understand the "HIPAA Authorization to Share Health Information" and agree to the terms:

X _____ Patient signature _____ Date _____ Parent or guardian signature (for patients under 18 years old) _____ Date

In addition, I authorize the disclosure of my health information to the following designated individual (optional):

_____ Designated individual (print name) _____ Relationship

B Patient Services Authorization

I have read and understand the "Patient Services Authorization" and hereby agree to the terms set forth in the Authorization, including receiving the described support services and the disclosure of my health information in connection with such services:

X _____ Patient signature _____ Date _____ Parent or guardian signature (for patients under 18 years old) _____ Date

C Marketing Opt-In

☐ I have read and understand "Opt-In to Receive Marketing Communications" and hereby agree to receive information from Biogen (optional).

D Patient Information

❑ Male ❑ Female

_____ First name _____ Last name

_____ Address

_____ E-mail address

_____ Home phone ❑ OK to leave a message

_____ Cell phone ❑ OK to leave a message

Preferred method of contact: ❑ E-mail ❑ Home ❑ Cell

Best time to reach me: ❑ Morning ❑ Afternoon ❑ Evening

_____ Adjusted gross income (this is your gross income from taxable sources minus allowable deductions, such as unreimbursed business expenses, medical expenses, alimony, and deductible retirement plan contributions)

_____ Date of birth: MM/DD/YYYY _____ SSN #

_____ City _____ State _____ ZIP code

Current Therapy Status

_____

_____

Have you previously tried ALPROLIX? ❑ Yes ❑ No

Factor provider (where you obtain factor)

_____ Name

_____ Address

_____ City _____ State _____ ZIP code

_____ Phone (optional)

E Insurance Benefit Information

➤ **Attach copies of both sides of patient's insurance card(s).**

_____ Primary insurance

_____ Policy # _____ Group #

_____ Insurance company phone

_____ Policyholder full name _____ Date of birth: MM/DD/YYYY

Pharmacy Benefit Manager information (if applicable)

_____ Name _____ Phone number

_____ Rx BIN _____ Rx PCN

_____ RxGrp _____ ID #

❑ **Check if no insurance**

F Healthcare Provider Information

_____ First name _____ Last name

_____ Address

_____ City _____ State _____ ZIP code

_____ Phone

_____ Clinical/hospital affiliation

❑ If you are a healthcare provider, check if you want the results of your patient's benefits investigation and eligibility for MyALPROLIX programs.

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INDICATIONS AND IMPORTANT SAFETY INFORMATION

Indications

ALPROLIX [Coagulation Factor IX (Recombinant), Fc Fusion Protein] is a recombinant DNA derived, coagulation Factor IX concentrate indicated in adults and children with Hemophilia B for:

- On-demand treatment and control of bleeding episodes
- Perioperative management of bleeding
- Routine prophylaxis to reduce the frequency of bleeding episodes

ALPROLIX is not indicated for induction of immune tolerance in patients with Hemophilia B.

Important Safety Information

Do not use ALPROLIX if you are allergic to ALPROLIX or any of the other ingredients in ALPROLIX.

Tell your healthcare provider if you have or have had any medical problems, take any medicines, including prescription and non-prescription medicines, supplements, or herbal medicines, have any allergies and all your medical conditions, including if you are pregnant or planning to become pregnant, are breastfeeding, or have been told you have inhibitors (antibodies) to factor IX.

Allergic reactions may occur with ALPROLIX. Call your healthcare provider or get emergency treatment right away if you have any of the following symptoms: difficulty breathing, chest tightness, swelling of the face, rash, or hives.

Your body can also make antibodies called "inhibitors" against ALPROLIX, which may stop ALPROLIX from working properly.

ALPROLIX may increase the risk of formation of abnormal blood clots in your body, especially if you have risk factors for developing clots.

Common side effects of ALPROLIX include headache and abnormal sensation of the mouth. These are not all the possible side effects of ALPROLIX. Talk to your healthcare provider right away about any side effect that bothers you or does not go away, and if bleeding is not controlled using ALPROLIX.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Please see full Prescribing Information. This is an electronic PDF from ALPROLIX.com.