NEOPHARM ISRAEL
NEOPHARM GROUP

CERTIFICATE: Vaccination and/or Prophylactic Antibiotics

This form must be completed and provided to Neopharm before initiation of therapy with SOLIRIS® (Eculizumab) or ULTOMIRIS® (Ravulizumab) as requested by the Israeli Ministry of Health

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

To be immediately transmitted via fax or as a scanned PDF via e-mail

To: NEOPHARM – Patient's Safety Unit	**Fax / Email:**	RMP@neopharmgroup.com; +972-3-9264237	**Page 1 of**	1

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

Information on Patient

Birth Date *(dd/mmm/yyyy)*		The patient 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/parent(s)/legal guardian(s).

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 antibiotic therapy *(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 Pharma Israel /Neopharm USE ONLY

The Patient Code:_____(will be completed by Alexion Pharma Israel/Neopharm).

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

Information collected on this form is used to ensure controlled distribution of Soliris® (eculizumab) and Ultomiris® (ravulizumab) according to conditions of marketing authorizations as approved by the Israeli Ministry of Health. Collected information is accessible to dedicated people of Alexion Pharm Israel/Neopharm and national health authorities only.

99-FEB-2022

This document was last approved in March 2021 by the Israeli Ministry of Health (MOH)