ONWARD

Start Form for

ZILBRYSQ® (zilucoplan)

Injection for Subcutaneous Use

Instructions for Prescribers

To get a patient who has been prescribed ZILBRYSQ® started in ONWARD™, please follow these steps:

1. Enroll in ZILBRYSQ REMS at www.ZILBRYSQREMS.com. (Once enrolled, you do not need to re-enroll for subsequent patients.)
2. Review the REMS safety information with your patient.
3. Complete the ZILBRYSQ® Start Form, providing all required information.
4. Have your patient read and sign the Patient Authorization sections of the Start Form.
5. Fax the completed Start Form to 1-833-FAX-UCB1 (**1-833-329-8221**) or email it to **ucbonward@rxallcare.com**.

Instructions for Patients

1. Read and sign the Patient Authorization sections of the Start Form to enroll in ONWARD.
2. If you would like us to communicate with you via email and/or text, make sure to check the appropriate consent boxes and provide your email address and/or mobile phone number.
3. You will receive a call from an ONWARD Care Coordinator to discuss the services being requested by you and/or your physician. Please note that when you receive this call, you may see "ONWARD" on your caller ID.

If you have any questions, please call us at 1-844-ONWARD1 (**1-844-669-2731**). A program associate is available to help you **Monday through Friday, 8 AM to 8 PM, Eastern Time**.

Please see Important Safety Information including Boxed Warning at the end of the document.

ZILBRYSQ® (zilucoplan) Injection for Subcutaneous Use Start Form

FAX: 1-833-FAX-UCB1 (1-833-329-8221) | ENROLL ONLINE: ONWARDhcp-enroll-ZILBRYSQ.com | QUESTIONS? CALL: 1-844-ONWARD1 (1-844-669-2731) | EMAIL: ucbonward@rxallcare.com

Services Requested: ☐ Benefit Investigation ☐ Financial Assistance ☐ PA Appeal Support ☐ Care Coordinator Support
☐ Claim Denial Support ☐ Patient Assistance Program (PAP) - Consent Required: see page 4

Step 1: Patient Information * Required field

☐ New to Therapy ☐ On Therapy

First Name* | Middle Initial | **Last Name***

Date of Birth* (MM/DD/YYYY) | **Phone Number*** ☐ Home ☐ Cell | Gender: M ☐ F ☐ Other ☐

Street Address* | Apt#

City* | **State*** | **ZIP*** | Preferred Language: ☐ English ☐ Spanish ☐ Other

Communication Preference: ☐ Email ☐ Phone ☐ Text | Email

Caregiver Information
By providing this information, you authorize ONWARD™ to communicate with this person regarding your health condition and services provided by the program.

First Name | Last Name | Relationship to Patient

Phone ☐ Home ☐ Cell | Primary Point of Contact: ☐ Patient ☐ Caregiver

Email | ☐ Caregiver is the authorized legal representative of the patient

Step 2: Insurance Information * Required

NOTE: *You may attach copies of the front and back of the patient's insurance card(s) in lieu of completing this section.*

☐ Check here if patient does not have insurance ☐ Check here to investigate meningococcal vaccine coverage	PRIMARY PHARMACY INSURANCE	PRIMARY MEDICAL INSURANCE (only required for vaccine coverage)	OTHER (e.g., Secondary)
INSURANCE PROVIDER			
INSURANCE PHONE#			
CARDHOLDER NAME			
RELATIONSHIP TO PATIENT			
MEMBER ID			
GROUP#			
BIN#			
PCN#			

Step 3: Prescriber Information * Required field

Prescriber First Name* | **Prescriber Last Name***

Specialty | **NPI#*** | Tax ID#

Supervising Physician | Supervising Physician NPI

Practice/Clinic Name

Address*

City | State | ZIP

Office Phone#* | Office Fax#

Office Contact Name | Office Contact Email

Office Contact Phone# | Office Contact Communication Preference: ☐ Phone ☐ Email

STEP 4: Clinical Information * Required field

ICD-10 Diagnosis* ☐ G70.00 ☐ G70.01 ☐ Other _____ MGFA Classification (I, II, III, IV, V): _____

MG-ADL Score _____ Date of Assessment _____

AChR Antibody Test: ☐ Positive ☐ Negative ☐ Not Known

Current Therapies:

- ☐ Eculizumab
- ☐ Efgartigimod
- ☐ Ravulizumab
- ☐ Oral Corticosteroids
- ☐ Acetylcholinesterase Inhibitors
- ☐ Other _____
- ☐ Rituximab
- ☐ IVIG
- ☐ SCIG
- ☐ PLEX

Non-steroidal ISTs

- ☐ Azathioprine
- ☐ Cyclophosphamide
- ☐ Cyclosporine
- ☐ Methotrexate
- ☐ Tacrolimus
- ☐ Mycophenolate

Previous Therapies:

- ☐ Eculizumab
- ☐ Efgartigimod
- ☐ Ravulizumab
- ☐ Oral Corticosteroids
- ☐ Acetylcholinesterase Inhibitors
- ☐ Other _____
- ☐ Rituximab
- ☐ IVIG
- ☐ SCIG
- ☐ PLEX

Non-steroidal ISTs

- ☐ Azathioprine
- ☐ Cyclophosphamide
- ☐ Cyclosporine
- ☐ Methotrexate
- ☐ Tacrolimus
- ☐ Mycophenolate

Medical Allergies: _____ ☐ No allergies

STEP 5: ZILBRYSQ® Prescription * Required field

ZILBRYSQ prescription will be triaged to PANTHERx Rare.
Your patient will be contacted by PANTHERx Rare to arrange for delivery of ZILBRYSQ.

Patient First & Last Name* _____ Date of Birth* (MM/DD/YYYY) _____

Patient Weight (kg)* _____ Date Weight Measured* _____

Prescriber to indicate prescribed ZILBRYSQ® dose:*

MEDICATION	STRENGTH/FORM	DIRECTIONS FOR ADMINISTRATION	QTY	REFILLS
ZILBRYSQ (zilucoplan)	☐ 16.6 mg/mL;pre-filled safety syringes	Inject one pre-filled syringe subcutaneously once daily as directed	28 pre-filled syringes	
	☐ 23.0 mg/mL;pre-filled safety syringes			
	☐ 32.4 mg/mL;pre-filled safety syringes			

Appropriate ancilliary supplies will be dispensed with the medication unless otherwise indicated.

Physician Attestation and Signature

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides; and 5) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements and I appoint UCB as my agent for the limited purposes of conveying this prescription by any means under applicable law only to the dispensing pharmacy. I understand that by signing this form, I am requesting support from UCB for Patients receiving ZILBRYSQ®. PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.

Print Prescriber First and Last Name:* _____

Prescriber Signature* _____ Date* _____

ATTN: If your local prescribing requirements call for submission of an electronic prescription, please submit to PANTHERx Rare, NPI # 1659762524

Patient Vaccine History/Prescription(s) (to be completed by healthcare provider)

The certified pharmacy provides education and support specific to vaccination requirements outlined in ZILBRYSQ® REMS. The ZILBRYSQ REMS program requires the certified dispensing pharmacy to contact the prescriber to assess the patient's vaccination status for up-to-date meningococcal vaccines (MenACWY and MenB) according to the current Advisory Committee on Immunization Practices (ACIP) recommendations including antibacterial drug prophylaxis if needed before treatment initiation and document the findings.
Completing the patient's vaccination history and/or submitting an order for vaccination(s) in the table below will reduce the need for additional follow-up with your office to meet this ZILBRYSQ REMS requirement. If you submit an order for vaccination(s) for your patient in the table below, the certified pharmacy will work with the patient to help coordinate their vaccination based on the patient's location and insurance coverage. Please complete the table as follows:

- In the Vaccination History section, document the brand administered, administration date of the most recent dose, and the characterization of the most recent dose (dose 1, dose 2, or booster) of the indicated vaccine.
- **In the Vaccine Prescription section, if you would like the certified pharmacy to help coordinate the indicated vaccination for your patient, please provide a prescription.**
- If urgent ZILBRYSQ therapy is indicated in a patient who is not up to date with both MenACWY and MenB vaccines according to ACIP recommendations, administer meningococcal vaccine(s) as soon as possible and provide the patient with antibacterial drug prophylaxis. If antibiotic prophylaxis is provided to the patient, please indicate the start date of antibiotic therapy: _____

Patient has received or is scheduled to receive the required vaccinations per ZILBRYSQ REMS guidelines. Please complete the following:

Patient Name _____ DOB: _____

ZILBRYSQ REMS REQUIREMENTS FOR PATIENTS WITH COMPLEMENT DEFICIENCY TO BEGIN TREATMENT WITH ZILBRYSQ. Current ZILBRYSQ REMS requirements available at: www.ZILBRYSQREMS.com		**VACCINATION HISTORY**	**VACCINE PRESCRIPTION**
MENINGOCOCCAL CONJUGATE (MenACWY)	• 2-dose series at least 8 weeks apart • Revaccinate every 5 years if risk remains	Most Recent Brand Administered: _____ Most Recent Dose Date: _____ Most Recent Dose Characterization: ☐ Series dose #1 ☐ Series dose #2 ☐ Booster If MenACWY history is not available, please select below: ☐ History Unknown ☐ Vaccine Not Received	Rx: ☐ Menactra® (MenACWY-D) ☐ Menveo® (MenACWY-CRM) ☐ MenQuadfi® (MenACWY-TT) SIG: _____ _____ Quantity: _____ Refills#: _____
SEROGROUP B MENINGOCOCCAL (MenB)	• 2-dose primary series MenB-4C at least 1month apart **or** • 3-dose primary series MenB-FHbp at 0, 1-2, 6 months —If dose 2 was administered at least 6 months after dose 1, dose 3 is not needed **Note:** MenB-4C (Bexsero) and MenB-FHbp (Trumenba) are **not** interchangeable (use same product for all doses in series). • 1 dose booster 1 year after primary series • Revaccinate every 2-3 years if risk remains	Most Recent Brand Administered: _____ Most Recent Dose Date: _____ Most Recent Dose Characterization: ☐ Series dose #1 ☐ Series dose #2 ☐ Series dose #3 (Only applicable to Trumenba) ☐ Booster If MenB history is not available, please select below: ☐ History Unknown ☐ Vaccine Not Received	Rx: ☐ Bexsero® (MenB-4C) ☐ Trumenba® (MenB-FHbp) SIG: _____ _____ Quantity: _____ Refills#: _____

If a prophylactic antibiotic was prescribed with ZILBRYSQ outside of this form, please indicate anticipated antibiotic start date:

Date _____ Prescribed duration of antibiotic use _____

Physician Attestation

The table completed above is accurate based on my clinical and professional judgment. I have reviewed the ZILBRYSQ REMS vaccination requirements and certify that I will complete or update meningococcal vaccinations or provide antibiotic prophylaxis to my patient in accordance with the ZILBRYSQ REMS and ACIP guidelines. PANTHERx is authorized to dispense as soon as possible.

Prescriber Signature (Stamps not accepted): _____ **Date** _____

Vaccine Prescription

Prescriber Signature (Stamps not accepted): _____ **Date** _____

Patient Authorization

Please see next page for required HIPAA Authorization

❑ **PAP Consent* (Required for the Patient Assistance Program):**
By checking here, applicants authorize ONWARD™ PAP and its Administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from the ONWARD PAP. Upon request, the ONWARD PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. For additional questions about eligibility, please call ONWARD at 1-844-669-2731 (1-844-ONWARD1).

❑ **Text Message Consent Language:**
By checking here, you agree to receive text messages from UCB ONWARD for patient support. Message and data rates may apply. Message frequency will vary based on need. Text "**HELP**" to **844669** for help. Text "**STOP**" to **844669** to cancel. If you have questions, call 1-844-669-2731 (1-844-ONWARD-1). For more information on how UCB will use your information, please view our privacy policy at www.ucb-usa.com/policy and our text messaging terms and conditions at www.ucbONWARD.com/Text-Terms-Conditions.

Terms of Use

UCB ONWARD Patient Support Text Messaging Terms of Use:

The UCB ONWARD Patient Support Text Messaging Program will send adherence and benefit information, as well as allow your Care Coordinator to check-in periodically. This text service is not medical information or medical advice and is not a replacement for seeking medical advice or care from your healthcare provider. Please consult your healthcare provider for any medical advice or information on your condition or treatments.

ONWARD text service is available on the following carriers: Participating carriers: AT&T, Verizon, Sprint, Boost, Virgin, T-Mobile. T-Mobile is not liable for delayed or undelivered messages. Minor carriers: Aio Wireless, Alaska Communications Systems (ACS), Appalachian Wireless (EKN), Bluegrass Cellular, Boost Mobile, Carolina West Wireless, CellCom, Cellular One of East Central IL (ECIT), Cellular One of Northeast Arizona, Cellular One of Northeast Pennsylvania, Chariton Valley Cellular, Coral Wireless (Mobi PCS), Cricket, Cross, C-Spire (CellSouth), Duet IP (Maximum Communications New Core Wireless), Element Mobile (Flat Wireless), Epic Touch (Elkhart Telephone), GCI, Golden State, Google Voice, Hawkeye (Chat Mobility), Hawkeye (NW Missouri), Illinois Valley Cellular, Inland Cellular, iWireless (Iowa Wireless), Keystone Wireless (Immix Wireless/PC Man), Metro PCS, Mosaic (Consolidated or CTC Telecom), MTA Communications, MTPCS (Cellular One Nation), Nex-Tech Wireless, Panhandle Communications, Peoples Wireless, Pine Cellular, Pioneer, RINA, Sagebrush Cellular (Nemont), SI Wireless/Mobile Nation, Simmetry (TMP Corporation), SouthernLinc, SRT Wireless, Thumb Cellular, Union Wireless, United Wireless, U.S. Cellular, Viaero Wireless, Virgin Mobile, and West Central (WCC or 5 Star Wireless). Message and data rates may apply. Alert frequency may vary.

Subscribers will opt-in via the patient enrollment form from "UCB, Inc". UCB will only share this information with its representatives and agents. Message frequency will vary based on need. Text "HELP" to 844669 for help. Text "STOP" to 844669 to cancel. Messages and data rates may apply for any messages sent to you from us and to us from you. If you have any questions about your text plan or data plan, it is best to contact your wireless provider. For all questions about the services provided by this short code, you can send an email to ONWARD@ucb.com or call 1-844-669-2731.

Alerts sent via SMS may not be delivered to you if your phone is not in range of a transmission site, or if sufficient network capacity is not available at a particular time. Even within a coverage area, factors beyond the control of your wireless carrier may interfere with message delivery, including the customer's equipment, terrain, proximity to buildings, foliage, and weather. You acknowledge that urgent alerts may not be timely received and that your wireless carrier does not guarantee that alerts will be delivered. Carriers are not liable for delayed or undelivered messages.

UCB reserves the right to terminate this service in whole or in part, at any time, without notice.

❑ **Marketing Consent (Optional):**
By checking here & providing your information, you acknowledge you are a U.S. resident and give UCB and its business partners permission to send you information or contact you and/or your healthcare provider regarding your disease as well as information on other related treatments, products and services, and for marketing and informational purposes by phone, email, or mail. You understand that UCB or its business partners will not sell your name, address, email address, or any other information to another party for their own marketing use.

Patient Authorization to Use/Disclose Health Information (Required)

HIPAA Authorization:*

By signing this form, I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy) that receives my prescription for a UCB medication, and other of my healthcare providers (together, "Providers") and each of my health insurers (together, "Insurers") to disclose information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and email addresses, telephone number, date of birth and Social Security Number (together, "Protected Health Information"), to UCB, Inc. and its agents, service providers, contractors and representatives (together, "UCB"), so that UCB may:

(i) enroll me in, and contact me about, UCB medication support programs.
(ii) provide me with educational materials, information, and services related to UCB medications.
(iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers.
(iv) conduct market analyses/research or other commercial activity, including aggregating my Protected Health Information with other data for such analyses.
(v) assist with analysis related to quality, efficacy, and safety for UCB medication, and, in some cases, contact you to follow up on adverse events in order to obtain additional information.
(vi) de-identify my Protected Health Information for use for any purpose under applicable law.

I understand that once my Protected Health Information has been disclosed to UCB, federal privacy laws may no longer protect the information and it may be subject to re-disclosure. I understand that one or more Provider and/or Insurer may receive payment from UCB for disclosing my Protected Health Information for some or all of the purposes listed above.

I understand that I am not required to sign this Patient Authorization to Use/Disclose Health Information Authorization, and that if I decline to sign, that will not affect my treatment (including the receipt of UCB medication), payment for treatment, insurance enrollment, or eligibility for insurance benefits, but it may mean that I will not receive the other services described above.

I understand that I may cancel (revoke) this Authorization at any time by calling ONWARD at 1-844-669-2731 (1-844-ONWARD-1) or mailing a letter with my notice of withdrawal to ONWARD, 50 Bearfoot Road, Northborough, MA 01532.

UCB shall provide timely notification of my cancellation (revocation) to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of cancellation (revocation) of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB as permitted by this Authorization.

However, canceling this Authorization will not affect any action(s) taken by my Providers or Insurers based on this Authorization before receipt of my notice of cancellation. This authorization expires 10 years from the date it was signed, or such earlier date as required by applicable law unless I cancel it beforehand. I understand that I have the right to receive a copy of this Authorization when it is signed.

Print Patient First and Last Name: _____

Date of Birth: _____

(If applicable) Print Authorized Representative First and Last Name: _____

Relationship to Patient: _____

Patient (or Authorized Representative)

Signature* _____

Date:* _____

INDICATION
ZILBRYSQ® (zilucoplan) is indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

IMPORTANT SAFETY INFORMATION INCLUDING BOXED WARNING

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

Life-threatening and fatal meningococcal infections have occurred in patients treated with complement inhibitors; ZILBRYSQ is a complement inhibitor. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early.

- **Complete or update meningococcal vaccination (for serogroups A, C, W, and Y, and serogroup B) at least 2 weeks prior to administering the first dose of ZILBRYSQ, unless the risk of delaying therapy outweighs the risk of developing a meningococcal infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccinations in patients receiving a complement inhibitor.**
- **Persons receiving ZILBRYSQ are at increased risk for invasive disease caused by *N. meningitidis*, even if they develop antibodies following vaccination. Monitor patients for signs of meningococcal infections and evaluate immediately if infection is suspected.**

Because of the risk of serious meningococcal infections, ZILBRYSQ is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called ZILBRYSQ REMS.

CONTRAINDICATIONS
ZILBRYSQ is contraindicated in patients with unresolved *Neisseria meningitidis* infection.

WARNINGS AND PRECAUTIONS
Serious Meningococcal Infections
Life-threatening and fatal meningococcal infections have occurred in both vaccinated and unvaccinated patients treated with complement inhibitors; ZILBRYSQ is a complement inhibitor. The use of ZILBRYSQ increases a patient's susceptibility to serious and life-threatening meningococcal infections (septicemia and/or meningitis) caused by any serogroup, including non-groupable strains.

Complete or update meningococcal vaccination (for both serogroups A, C, W, and Y [MenACWY] and serogroup B [MenB]) at least 2 weeks prior to administering the first dose of ZILBRYSQ, according to current ACIP recommendations for meningococcal vaccinations in patients receiving a complement inhibitor.

If urgent ZILBRYSQ therapy is indicated in a patient who is not up to date with both MenACWY and MenB vaccines according to ACIP recommendations, administer meningococcal vaccine(s) as soon as possible and provide the patient with antibacterial drug prophylaxis.

Closely monitor patients for early signs and symptoms of meningococcal infection and evaluate patients immediately if infection is suspected. Withhold administration of ZILBRYSQ in patients who are undergoing treatment for meningococcal infection until the infection is resolved.

ZILBRYSQ REMS
Due to the risk of meningococcal infections, ZILBRYSQ is available only through a restricted program under a REMS called ZILBRYSQ REMS.

Under the ZILBRYSQ REMS, prescribers must enroll in the program. Prescribers must counsel patients about the risk of meningococcal infection, provide the patients with the REMS educational materials, and ensure patients are vaccinated with meningococcal vaccines. Additional information on the REMS requirements is available at www.ZILBRYSQREMS.com or 1-877-414-8353.

Other Infections
ZILBRYSQ blocks terminal complement activation; therefore, patients may have increased susceptibility to infections, especially with encapsulated bacteria, such as infections caused by *Neisseria meningitidis* but also *Streptococcus pneumoniae*, *Haemophilus influenzae*, and to a lesser extent, *Neisseria gonorrhoeae*. Administer vaccinations for the prevention of *Streptococcus pneumoniae* and *Haemophilus influenzae type b* (Hib) infections according to ACIP guidelines. Persons receiving ZILBRYSQ are at increased risk for infections due to these bacteria, even after vaccination.

Pancreatitis And Other Pancreatic Conditions
Pancreatitis and pancreatic cysts have been reported in patients treated with ZILBRYSQ. Patients should be informed of this risk before starting ZILBRYSQ. Obtain lipase and amylase levels at baseline before starting treatment with ZILBRYSQ. Discontinue ZILBRYSQ in patients with suspected pancreatitis and initiate appropriate management until pancreatitis is ruled out or has resolved.

ADVERSE REACTIONS
In a placebo-controlled study, the most common adverse reactions (reported in at least 10% of gMG patients treated with ZILBRYSQ) were injection site reactions, upper respiratory tract infections, and diarrhea.

Please refer to the full Prescribing Information provided by the UCB representative and visit www.ZILBRYSQHCP.com