Alexion Pharma and AstraZeneca and Biologix FZco processes personal data relating to patients receiving Soliris/Ultomiris and to health professionals involved in their therapeutic management, for the purposes of managing and reducing the risk linked to the use of Soliris/Ultomiris as legally required. Such personal data will refer to the patient's date of Birth (only month and year), treatment type and prescribed medication linked to the certificate of vaccination, while for healthcare professionals we process personal data such as name, hospital when providing the patient's COV and when identified as the treating physicians and email address when submitting the E-COV. You may contact us at any time to ask what Personal Data we process about you, request that we correct inaccurate Personal Data, opt out of or suppress certain Personal Data processing, request deletion of your Personal Data, impose restrictions on our processing of your Personal Data, right to object on grounds relating to your particular situation, at any time to the processing of your personal data by us, and withdraw your consent to certain processing of your Personal Data. If such a request places Alexion/AstraZeneca or its affiliates or Biologix Fzco in breach of its obligations under applicable laws, regulations or codes of practice, then Alexion/AstraZeneca may not be able to comply with your request. To exercise your rights: privacy@alexion.com or privacy@astrazeneca.com

CERTIFICATE OF VACCINATION

This form must be completed and provided to Biologix FZco before initiation of therapy with SOLIRIS® (Eculizumab) or ULTOMIRIS® (Ravulizumab)

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

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

To: Biologix FZco	**Fax /Email:**	**+966 11 4634362** **RMP-KSA@biologixpharma.com**	**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 ☐ gMG ☐ NMOSD	Other: (specify)	
☐ **ULTOMIRIS®** *(ravulizumab)*	**Indication**	☐ PNH ☐ aHUS ☐ gMG ☐ NMOSD	Other: (specify)	

To be included only if product is available through GATM

Global Access to Medicines (GATM) patient ID:

Information on Patient

Birth Date (*mm/yyyy*)	___ ___ / ___ ___ ___ ___	The patient is/is to be included in the disease registry: ☐ **Yes** ☐ **No** ***To be included only for applicable markets***

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), provide the Data Privacy Notice to the patient and all necessary information, including the Patient Card (paper copy) and relevant educational materials before initiating the complement inhibitor treatment.
- The patient is vaccinated against meningococcal infections at least 2 weeks prior to receiving the complement inhibitor treatment. Patients who initiate the complement inhibitor treatment less than 2 weeks after receiving a meningococcal vaccine will receive treatment with appropriate prophylactic antibiotics until 2 weeks after vaccination.
- The patient is vaccinated against all available meningococcal infection serotypes of *Neisseria meningitidis* according to national vaccination guideline.

Signature: _____	**Date:***(dd-mmm-yyyy):* __ __ / __ __ __ / __ __ __ __

After validation by Biologix FZco, the patient will be allocated a unique Patient Identification (ID) code which will be sent to you via the contact details you have provided on this certificate.
The Patient ID and patients' date of birth **MUST** be quoted on all drug orders.

FOR INTERNAL USE ONLY

SAP Reference Code: _____ will be completed by Alexion/AZ.