ENROLLMENT FORM

Phone: 888-APELLIS (888-273-5547) • Fax: 888-405-6966

Please ensure you and your patient complete all required information on the form and sign where indicated.

***Required Field**

SYFOVRE® (pegcetacoplan injection) 15 mg / 0.1 mL

*Section 1. Support Request

☐ Check here for all available services *(Checking "all" allows for support services throughout the patient journey, but only when needed)*
OR choose individual services below:

☐ Benefits Investigation Only ☐ Prior Authorization Assistance ☐ Co-pay Program *(commercially insured patients)* ☐ Patient Assistance Program *(uninsured or underinsured patients)*

Section 2. Patient Information

*First Name: _____ Middle Initial: ____ *Last Name: _____

Gender: ☐ Male ☐ Female ☐ Other: _____ *Date of Birth (MM/DD/YYYY): ____ /____ /_____

*Preferred Phone: _____ ☐ Home Phone ☐ Mobile Phone Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Section 3. Caregiver Information *(optional)*

Does patient have a caregiver with whom they would like ApellisAssist to share information? ☐ Yes ☐ No (If yes, please complete this section)

Caregiver First Name: _____ Last Name: _____

Preferred Phone: _____ ☐ Home Phone ☐ Mobile Phone Email: _____

What is the caregiver's relationship to the patient? ☐ Legal Guardian ☐ Spouse ☐ Sibling ☐ Other: _____

Section 4. Patient Insurance

*Does patient have insurance? ☐ Yes ☐ No

Primary Insurance (☐ If copy of card is attached, check here)

*Payer Name and Payer ID: _____

Phone: _____

Policyholder Name: _____

Policyholder DOB: _____

*Policy Number: _____

Employer/Group Number: _____

Secondary Insurance (☐ If copy of card is attached, check here)

*Payer Name and Payer ID: _____

Phone: _____

Policyholder Name: _____

Policyholder DOB: _____

*Policy Number: _____

Employer/Group Number: _____

(Optional Section) Pharmacy (PBM) Name: _____

PBM Group ID: _____ PBM BIN/PCN: _____ PBM Phone Number: _____

Section 4.1 Financial Information (Must be completed for Patient Assistance Program requests only)

How many people live in the patient's household? _____

Total annual household income (including salary/wages; Social Security income; disability income; any other income):

☐ Less than $150,000 ☐ Greater than $150,000

Supporting documentation may be required. ApellisAssist may also ask for proof of income at any time for audit/verification.

*Section 5. Patient Authorization **This form cannot be processed without the patient's signature.**

☐ I have read and agree to Section 10.1 Authorization to Share Personal Health Information (*required*)

☐ I have read and agree to Section 10.2 Authorization to Enroll in ApellisAssist Patient Support Program (*required*)

☐ I have read and agree to Section 10.3 Authorization to Receive Marketing Communications (*optional*)

_____ _____/_____/_____

Patient Signature Date (MM/DD/YYYY)

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SYFOVRE® (pegcetacoplan injection) 15 mg / 0.1 mL

*Patient First Name: _____ Middle Initial: ____ *Last Name: _____

Section 6. Prescribing Physician Information

Site of Service: ☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgical Center ☐ Other: _____

*Practice/Facility Name: _____

*Physician Name: _____ Physician Specialty: _____

*Phone: _____ Fax: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Practice Tax ID#: _____ Physician Tax ID#: _____ Physician PTAN#: _____

*NPI: _____ ☐ Practice NPI ☐ Physician NPI

Section 7. Office Contact Information

*Primary Office Contact Name: _____

*Phone: _____ Fax: _____ Email: _____

*Section 8. Prescription Information ☐ Buy and bill ☐ Specialty pharmacy

Geographic Atrophy Diagnosis Select one diagnosis as primary. For additional diagnoses, please use the "secondary diagnosis" section below.			
Nonexudative age-related macular degeneration	RIGHT EYE	LEFT EYE	BILATERAL
Advanced atrophic **without** subfoveal involvement	☐ **H35.3113**	☐ **H35.3123**	☐ **H35.3133**
Advanced atrophic **with** subfoveal involvement	☐ **H35.3114**	☐ **H35.3124**	☐ **H35.3134**

Secondary Diagnosis: ☐☐☐.☐☐☐☐ Has patient started treatment? ☐ Yes, date of next treatment: _____

☐ No, anticipated date of first treatment: _____

Dispense: ____ vial(s) of SYFOVRE® (pegcetacoplan injection) NDC: **73606-0020-01** Refills #: _____

SIG: ☐ Inject 15 mg (0.1 mL) intravitreally once every _____ days (25 to 60)

Ancillary supplies - Rx only: ☐ IVT Injection Kit (29G thin-wall injection needle and 5M filter needle)

*Section 9. Physician Declaration and Authorization

This form allows Apellis Pharmaceuticals, Inc., its affiliates, representatives, agents, partners, vendors and contractors ("Apellis") to provide patient support, resources and education ("Patient Resources") to eligible patients who have been prescribed SYFOVRE. I have the necessary written authorization from the patient referenced above, or the patient's legal guardian, to release to Apellis the medical and/or other patient information included herein for allowing participation in programs and services offered through ApellisAssist, which may include, without limitation: (1) financial assistance programs; (2) verifying insurance coverage and/or evaluating the patient's eligibility for alternate funding; and (3) Patient Resources. I certify that: (i) the information in this form is complete and accurate to the best of my knowledge; (ii) the patient on this form has a diagnosis for an FDA-approved indication for SYFOVRE; (iii) any Patient Resource provided through Apellis to my patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use an Apellis medication or Patient Resource. I prescribed SYFOVRE solely on my clinical determination and medical necessity, and no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge, or for related medical procedures and services; nor will the free product be sold, traded, or distributed for sale. I will notify Apellis immediately if SYFOVRE is no longer medically necessary for this patient or if my patient's insurance status changes; (iv) I authorize Apellis to forward the above prescription to the applicable pharmacy as allowed under applicable law.

The SYFOVRE Co-pay Program is for eligible patients enrolled in the ApellisAssist® program, are commercially insured, and are not covered under government insurance programs such as Medicare, Medicaid, VA/DoD, or TRICARE. The program assists only with the cost of SYFOVRE and its administration (injection) up to the program maximum. It does not assist with the cost of other administrations, medicines, procedures or office visits. Eligible patients residing in Massachusetts or Rhode Island can only receive assistance with the cost of SYFOVRE but not the cost of its administration. Patients receiving assistance through another program or foundation, free trial, or other similar offer or program, are not eligible for the program. Apellis reserves the right to modify or terminate the program at any time without notice.

If I seek reimbursement under the SYFOVRE Co-pay Program on behalf of my patient(s), I certify the following for each request: (i) I have provided true and accurate information; (ii) the expenses requested for reimbursement are eligible under the program, were actually incurred and not paid by the patient or any party; (iii) the patient is not insured under Medicare, Medicaid, VA/DoD, TRICARE, or any other federal or state government funded program and has received SYFOVRE for the FDA-approved indication; (iv) I have not requested or received, and will not request or receive, any payments from the patient or any party for the amounts I seek reimbursement under the program, and if I do receive such payment or reimbursement, I will immediately return it.

_____ OR _____ _____/_____/_____

Physician Signature (Dispense As Written) **Physician Signature** (If Drug Substitution Allowed) Date (MM/DD/YYYY)

This form cannot be processed without the physician's signature (no stamps).

*Patient First Name: _____ Middle Initial: ____ *Last Name: _____

Please read the following authorizations carefully, and if you agree, provide your signature on page 1 of this form. You may keep a copy of this form for your records.

*Section 10. Patient Authorizations

Section 10.1 Authorization to Share Personal Health Information

I authorize my healthcare team and staff, my pharmacies, and my insurance ("Health Care Providers and Insurers") to use and to share my personal health information, including information relating to my medical condition, treatment, care management, health insurance, and all information provided on any prescription form for SYFOVRE ("My Information") to Apellis Pharmaceuticals, Inc. and its affiliates, vendors, and other agents (collectively, "Apellis") for the purposes of receiving services from ApellisAssist ("Patient Support Program"), which include but are not limited to:

- receiving product support and resources from Apellis, including insurance verification, product coverage, and financial assistance;
- disease and medication-related educational resources and communications, including disease state education and information about the medication by an Apellis Care Educator;
- and communications with me and my Health Care Providers and Insurers about my medical condition, treatment, care management, and health insurance

I also authorize ApellisAssist to share my information with my caregiver, if I have selected that option in this form.

I further authorize Apellis and its agents to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Apellis may receive from other sources.

Once My Information has been shared with Apellis, I understand that it is outside of the control of my Health Care Providers and Insurers, and that the recipient may share this information with others and may not be required to comply with federal privacy laws or otherwise protect the information. However, I also understand that Apellis will protect My Information by sharing it only for the purposes for which I have provided permission. I understand and agree that if my SYFOVRE is received through a specialty pharmacy, that specialty pharmacy may receive payment from Apellis in exchange for giving My Information to Apellis. I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to receive health insurance benefits or my ability to get my medications or medical advice and treatment from my physician.

However, if I do not sign this Authorization, I understand I will not be able to participate and receive services from the Patient Support Program. I understand that this Authorization expires the earlier of (1) 10 years from the date signed above, (2) 1 year after the date of my last prescription, or (3) as may be required by applicable state law.

*Section 10. Patient Authorizations (continued)

I may change my mind and cancel this Authorization at any time by calling 888-APELLIS (888-273-5547), by notifying Apellis in writing at Attn: Privacy Office, Apellis Pharmaceuticals, Inc., 100 5th Avenue, Waltham, MA, 02451, or by emailing **privacy@apellis.com**. Cancellation of this Authorization will end further uses and sharing of My Information with Apellis and my participation in the Patient Support Program, but will not affect any uses or sharing of My Information based on this Authorization before cancellation. I understand I may request a signed copy of this Authorization.

Section 10.2 Authorization to Enroll in ApellisAssist Patient Support Program

I authorize Apellis to collect My Information from me, my caregivers, and my Health Care Providers and Insurers, and to use and disclose My Information to provide product support and resources, including enrollment in the Patient Support Program. The Patient Support Program resources include, but are not limited to, providing:

i) reimbursement and financial assistance information and

ii) disease and medication-related educational resources and communications, including education provided by an Apellis Care Educator including but not limited to Geographic Atrophy ("Patient Resources"), if approved by prescribing physician.

I also authorize Apellis to communicate with me and/or my caregivers by mail, phone, email and/or text message for the Patient Support Program to receive education. I authorize Apellis to provide me and/or my caregivers with appropriate education on my disease state and medication by an Apellis Care Educator, and to provide me and/or my caregivers with helpful information and resources about SYFOVRE and Geographic Atrophy.

I understand that this education does not include medical advice and it does not replace or substitute the medical treatment and care I receive by my doctor. I further certify that I have discussed this with my doctor, and my doctor informed me of the potential risks and side effects associated with SYFOVRE and how to manage them if they occur. By signing above, I certify that the information contained in this form is complete and accurate to the best of my knowledge.

I authorize Apellis to send text messages to the phone number(s) I provide. I understand this consent is not a condition of participating in ApellisAssist or purchasing anything from Apellis. I may revoke this authorization and choose not to receive automated calls and text messages by replying STOP to any such text from Apellis or by contacting Apellis in writing at the address in section 10.1.

For support via the SYFOVRE Co-pay Program (if applicable), I certify that I am not a beneficiary of a federal or state healthcare program, including but not limited to Medicaid, Medicare, VA, DoD, TRICARE, or any state pharmaceutical assistance programs. I understand that once enrolled, Apellis will pay my eligible co-pay

*Section 10. Patient Authorizations (continued)

and/or co-insurance costs up to the program maximum, but that any costs over the program maximum or those that are not eligible for payment under the SYFOVRE Co-pay Program are my responsibility.

For support via the Patient Assistance Program (if applicable), I authorize Apellis to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that upon request, Apellis will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize Apellis to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources to estimate my income in conjunction with the patient assistance program eligibility determination process, if applicable. I certify that I will not submit a claim for reimbursement for any free product I receive from Apellis to any payer, including Medicare and Medicaid; and that no free product may be sold, traded, or distributed for sale. By signing, I verify that the information on this application and other supporting documentation is complete and accurate. I also verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs, or any other form of insurance. If my insurance coverage should change, I will notify ApellisAssist immediately.

Section 10.3 Authorization to Receive Marketing Communications (*optional*)

I authorize Apellis to communicate with me (by mail, phone, text and/or email) for marketing purposes or to otherwise provide me with information about Apellis products, services, and programs or other topics of interest, and to conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information I provide may be used by Apellis to help develop new products, services, and programs. I understand that I do not need to provide this authorization to receive marketing communications to participate in the Patient Support Program through ApellisAssist. I understand that this authorization will be in effect until such time as I opt-out of communications from Apellis.

I understand that I may revoke the Authorizations and choose not to receive information from Apellis by clicking the "unsubscribe" link provided in emails I receive from Apellis, calling Apellis at 888–APELLIS (888–273–5547), mailing a letter to Attn: Privacy Office, Apellis Pharmaceuticals, Inc., 100 5th Avenue, Waltham, MA, 02451, or emailing **privacy@apellis.com**.

Indication and Important Safety Information

INDICATION

SYFOVRE® (pegcetacoplan injection) is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

- SYFOVRE is contraindicated in patients with ocular or periocular infections, and in patients with active intraocular inflammation

WARNINGS AND PRECAUTIONS

- **Endophthalmitis and Retinal Detachments**
  - Intravitreal injections, including those with SYFOVRE, may be associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering SYFOVRE to minimize the risk of endophthalmitis. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately.
- **Retinal Vasculitis and/or Retinal Vascular Occlusion**
  - Retinal vasculitis and/or retinal vascular occlusion, typically in the presence of intraocular inflammation, have been reported with the use of SYFOVRE. Cases may occur with the first dose of SYFOVRE and may result in severe vision loss. Discontinue treatment with SYFOVRE in patients who develop these events. Patients should be instructed to report any change in vision without delay.
- **Neovascular AMD**
  - In clinical trials, use of SYFOVRE was associated with increased rates of neovascular (wet) AMD or choroidal neovascularization (12% when administered monthly, 7% when administered every other month and 3% in the control group) by Month 24. Patients receiving SYFOVRE should be monitored for signs of neovascular AMD. In case anti-Vascular Endothelial Growth Factor (anti-VEGF) is required, it should be given separately from SYFOVRE administration.
- **Intraocular Inflammation**
  - In clinical trials, use of SYFOVRE was associated with episodes of intraocular inflammation including: vitritis, vitreal cells, iridocyclitis, uveitis, anterior chamber cells, iritis, and anterior chamber flare. After inflammation resolves, patients may resume treatment with SYFOVRE.
- **Increased Intraocular Pressure**
  - Acute increase in IOP may occur within minutes of any intravitreal injection, including with SYFOVRE. Perfusion of the optic nerve head should be monitored following the injection and managed as needed.

ADVERSE REACTIONS

- Most common adverse reactions (incidence ≥5%) are ocular discomfort, neovascular age-related macular degeneration, vitreous floaters, conjunctival hemorrhage.

Please see full Prescribing Information for more information.