ENROLLMENT FORM

Phone: 888-APELLIS (888-273-5547) • Fax: 888-405-6966 • SyfovreECP.com
Hours of operation: 8 AM–8 PM ET M–F

SYFOVRE™ (pegcetacoplan injection) 15 mg / 0.1 mL

Please ensure you and your patient complete all required information on the form and sign where indicated.
Sections that contain patient information are highlighted with this purple background.

***Required Field**

*Section 1. Support Request

☐ **Check here for all available support services OR choose individual services below:**

ACCESS SERVICES
- ☐ Benefits Investigation
- ☐ Prior Authorization Assistance

FINANCIAL ASSISTANCE
- ☐ Co-pay Program *(commercially insured patients)*[a]
- ☐ Patient Assistance Program *(uninsured or underinsured patients)*

PATIENT SUPPORT RESOURCES
- ☐ Adherence/Education Program Enrollment
- ☐ Update Existing ApellisAssist® Patient Record

[a]The SYFOVRE Co-pay Program is for eligible patients who are enrolled in the ApellisAssist® program, are commercially insured, and are not covered under government insurance programs such as Medicare, Medicaid, VA/DoD, or TRICARE. Apellis reserves the right to modify or terminate the program at any time without notice.

*Section 2. Patient Information

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

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

Home Phone: _____ Mobile Phone: _____ Email: _____

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

Patient Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

☐ Agree to receive text messages ☐ Agree to receive voicemails Best time to call/communicate: ☐ AM ☐ PM

Patient Preferred Communication: ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Text Patient is a US resident: ☐ Yes ☐ No

Section 3. Caregiver Information

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: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

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

Caregiver Preferred Communication: ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Text

*Section 4. Patient Insurance

Does patient have insurance (third party or private)? ☐ Yes ☐ No (If no, please skip to **Section 4.1 Financial Information**)

Medicare Beneficiary ID# (Medicare/Medicare Advantage Plans only): _____

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

Payer Name: _____

Phone: _____

Policyholder Name: _____

Policy Number: _____

Employer/Group Number: _____

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

Payer Name: _____

Phone: _____

Policyholder Name: _____

Policy Number: _____

Employer/Group Number: _____

(Optional Section) Pharmacy (PBM) Name: _____

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

Section 4.1 Financial Information

(If you checked "No" above, denoting that patient does not have insurance, please complete section below.)

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

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

☐ $0 to $100,000 ☐ $100,001 to $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.

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*Section 5. 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 NPI: _____ Practice Tax ID#: _____
Physician NPI: _____ Physician Tax ID#: _____

*Section 6. Office Contact Information

Primary Office Contact Name: _____
Phone: _____ Fax: _____ Email: _____
Preferred Communication: ☐ Phone ☐ Email ☐ Text

*Section 7. Prescription Information

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)

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: _____

*Section 8. Physician Declaration and Authorization

The purpose of this form is to permit Apellis Pharmaceuticals, Inc., its affiliates, representatives, agents, and contractors ("Apellis") to provide patient support and resources to eligible patients who have been prescribed SYFOVRE. I have received the necessary written authorization from the patient referenced above, or the patient's legal guardian, to release to Apellis and its third-party business partners, vendors, and other agents ("Agents") the medical and/or other patient information included in this form for the purposes of participating in programs and services offered through ApellisAssist, which may include, but are not limited to, any of the following: (1) participating in financial assistance programs; (2) verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding; and (3) other patient support services, including patient education ("Patient Resources"). By signing below, I certify that: (i) the information contained in this form is complete and accurate to the best of my knowledge; (ii) the patient named on this form has a diagnosis for an FDA-approved indication for SYFOVRE; (iii) any Patient Resource provided through Apellis on behalf of any 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 for anyone. My decision to prescribe SYFOVRE was based solely on my clinical determination and medical necessity, and I understand that 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 should 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's treatment or if my patient's insurance status changes; (iv) I have complied with all prescription requirements and understand non-compliance could result in further outreach by the patient's specialty pharmacy; (v) I authorize Apellis to forward the above prescription to the applicable pharmacy by any means allowed under applicable law.

☐ I authorize Apellis to provide Patient Resources to my patient, including education by an Apellis Care Educator ("ACE") on Geographic Atrophy. I understand that this does not include individual treatment or medical advice to my patient, and it does not replace or substitute the medical treatment and care provided by me as the patient's healthcare provider. I further certify that I have discussed this education with my patient, and informed my patient of the risks associated with the medication and how to manage any potential side effects that may arise *(optional)*.

_____ _____ _____/_____/_____
Physician Signature (Dispense As Written) 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: _____

*Section 9. Patient Authorizations

Section 9.1 Authorization to Share Personal Health Information

Please read the following carefully, then sign and date where indicated.
You may keep a copy of this form for your records.

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 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 below, (2) 1 year after the date of my last prescription, or (3) as may be required by applicable state law.

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

*Section 9. 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.

☐ By checking this box, I authorize ApellisAssist to contact and share my personal health information with my authorized caregiver/alternative contact listed in section 3.

_____ _____/_____/_____

Patient Signature Date (MM/DD/YYYY)

This form cannot be processed without the patient's signature.

Section 9.2 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.

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

*Section 9. Patient Authorizations (continued)

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 below, 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 above on page 4.

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 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.

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

*Section 9. Patient Authorizations (continued)

Section 9.3 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**.

☐ I have read, understand, and agree to Section 9.2 Authorization to Enroll in ApellisAssist Patient Support Program on pages 4-5 *(check this box and sign below in order to receive ApellisAssist services).*

☐ I have read, understand, and agree to Section 9.3 Authorization to Receive Marketing Communications above *(optional)*.

_____
Patient Name (Printed Name)

_____ _____/_____/_____
Patient Signature Date (MM/DD/YYYY)

This form cannot be processed without the patient's signature.

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

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.
- **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.