

How to complete the EMPAVELI Start Form

This guide provides step-by-step instructions for completing the EMPAVELI Start Form to initiate treatment for your patients. Each section includes key details to help ensure accuracy and support a smooth start to care.



Questions? Our ApellisAssist[®] team is here to help!

1-866-MY-APL-ASSIST (1-866-692-7527)
8 AM-8 PM ET, Monday-Friday

INDICATION

EMPAVELI[®] (pegcetacoplan) is indicated for the treatment of adult and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria.

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS INFECTIONS CAUSED BY ENCAPSULATED BACTERIA

EMPAVELI, a complement inhibitor, increases the risk of serious infections, especially those caused by encapsulated bacteria, such as *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B. Life-threatening and fatal infections with encapsulated bacteria have occurred in patients treated with complement inhibitors. These infections may become rapidly life-threatening or fatal if not recognized and treated early.

- Complete or update vaccination for encapsulated bacteria at least 2 weeks prior to the first dose of EMPAVELI, unless the risks of delaying therapy with EMPAVELI outweigh the risks of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria in patients receiving a complement inhibitor.
- Patients receiving EMPAVELI are at increased risk for invasive disease caused by encapsulated bacteria, even if they develop antibodies following vaccination. Monitor patients for early signs and symptoms of serious infections and evaluate immediately if infection is suspected.

Because of the risk of serious infections caused by encapsulated bacteria, EMPAVELI is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the EMPAVELI REMS.

Please see full Important Safety Information on [pages 8-9](#) and accompanying full [Prescribing Information](#), including [Boxed WARNING](#) regarding serious infections caused by encapsulated bacteria, and [Medication Guide](#).

Page 1: Patient & Caregiver Information

Please complete all pages of the Start Form to the best of your ability. To assist you and your patient in getting started, key fields are highlighted below to help guide you through the form.



The patient or designated caregiver may sign the form in the office prior to submission. Alternatively, ApellisAssist can attempt to obtain their consent once the form is received.

EMPAVELI REMS

Certification in the EMPAVELI REMS is required before writing your first prescription.

Section I: Patient Information

Fill out all fields, including full name, date of birth, and address. Double-check for any missing or incorrect information.

Section II: Patient Consents

Patient or caregiver signature is required in both sections A and B to enroll in patient support through ApellisAssist and receive self-administration training and education from the Apellis Care Educator (ACE).

ApellisAssist Opt-In

Assist patients with reading and understanding the consent to enroll in the patient support program, ApellisAssist. Patients should understand that signing these authorizations allows Apellis to provide them product support while taking EMPAVELI.

Section III: Caregiver Information

This section is required for patients under the age of 18.

Thank you for your form submission, which has been captured on the following date: _____

ApellisAssist[®]

HEALTHCARE PROVIDER FORM
Phone: 1-866-MY-APL-ASSIST | (1-866-692-7527)
Fax: 1-888-754-1285

**EMPAVELI[®] (pegcetacoplan)
Nephrology Start Form**

1. Visit EMPAVELIREMS.com to get certified in the EMPAVELI REMS before writing your first prescription. You will only need to register once. REMS certification is required to dispense EMPAVELI to your patient.
2. Review the REMS requirements with your patient.
3. Have the patient or caregiver sign the Patient Consents section, section II below.
4. Complete all remaining fields on pages 1-6.

I. Patient Information (to be completed by patient or patient caregiver)

First Name: _____ MI: _____ Email: _____
Last Name: _____ Preferred Phone: _____
Date of Birth (mm/dd/yy): _____ ☐ Allow voicemail messages containing detailed medical information on this phone number
Sex: ☐ Male ☐ Female Alternative Phone: _____
Street Address: _____ ☐ Allow voicemail messages containing detailed medical information on this phone number
City: _____ State: _____ ZIP Code: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

II. Patient Consents (to be completed by patient or patient's caregiver; caregiver signature is required for patients under the age of 18)

Prior to completing the EMPAVELI Start Form, please share the Enrollment and Privacy Terms ([page 7](#)) with your patient or their caregiver and have them complete sections A, B, and C below.

A. HIPAA Authorization ([see section A on page 7](#))

By signing this form, I attest that I have read and agree to the HIPAA Authorization on page 7, section A. I understand I am entitled to a copy of this signed authorization.

Signature of patient or caregiver: _____ Date: _____

B. Consent to Enroll in Patient Support through ApellisAssist[®] and Receive Self-Administration Training and Education ([see section B on page 7](#))

I have read and I understand the Patient Support and Self-Administration Training and Education enrollment terms on page 7, section B and agree to the terms.

Signature of patient or caregiver: _____ Date: _____

C. Marketing Consent (optional)

☐ I consent to receive marketing communications from Apellis Pharmaceuticals, Inc., about its programs, products, services, and research opportunities. I understand I can opt-out anytime and review Apellis's privacy practices at <https://apellis.com/privacy-policy/>

III. Caregiver Information (required for patients under the age of 18)

Caregiver First Name: _____ Last Name: _____
Preferred Phone: _____ Email: _____
What is the caregiver's relationship to the patient? ☐ Parent/Legal Guardian ☐ Spouse ☐ Other: _____

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on pages 10-11, and the full Prescribing Information, and Medication Guide.

Apellis 1

Please see full Important Safety Information on pages 8-9 and accompanying full Prescribing Information, including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and Medication Guide.

Page 2: Insurance & Clinical Information

Patient Information

Be sure the patient's name and DOB are filled out on every page in case the pages get separated while faxing the form to PANTHERx[®] Rare, our Specialty Pharmacy Partner.

Section IV: Insurance Information

Fill out the insurance information section of the Start Form OR send copies (front and back) of the patient's insurance cards with the Start Form.

Section V: Clinical Information

Confirm the indication for your patient by checking the appropriate box. Enter the relevant diagnosis code for the patient's indication. If needed, a list of possible diagnosis codes is available on page 9 of the Start Form. The indication and ICD-10 code are essential for PANTHERx to conduct a benefit investigation and process the prescription request.

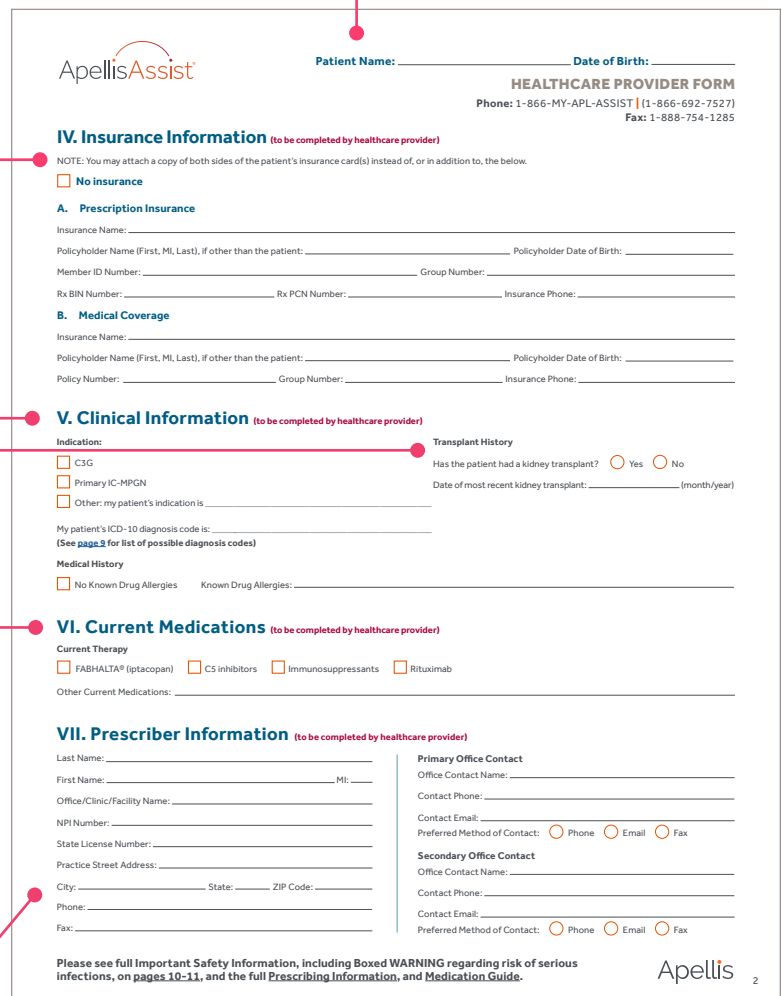
Please make sure to indicate if your patient has had a kidney transplant. This will help PANTHERx's pharmacists with counseling the patient on the administration of EMPAVELI.

Section VI: Current Medications

Designate whether your patient is currently taking any other medications.

Section VII: Prescriber Information

Fill out the prescriber information and ensure you enter the preferred office contact as PANTHERx may reach out to the primary or secondary contact for additional information.



ApellisAssist[®] Patient Name: _____ Date of Birth: _____

HEALTHCARE PROVIDER FORM
Phone: 1-866-MY-APL-ASSIST | (1-866-692-7527)
Fax: 1-888-754-1285

IV. Insurance Information (to be completed by healthcare provider)
NOTE: You may attach a copy of both sides of the patient's insurance card(s) instead of, or in addition to, the below.

☐ No insurance

A. Prescription Insurance
Insurance Name: _____
Policyholder Name (First, MI, Last), if other than the patient: _____ Policyholder Date of Birth: _____
Member ID Number: _____ Group Number: _____
Rx BIN Number: _____ Rx PCN Number: _____ Insurance Phone: _____

B. Medical Coverage
Insurance Name: _____
Policyholder Name (First, MI, Last), if other than the patient: _____ Policyholder Date of Birth: _____
Policy Number: _____ Group Number: _____ Insurance Phone: _____

V. Clinical Information (to be completed by healthcare provider)

Indication:
☐ C3G
☐ Primary IC-MPGN
☐ Other: my patient's indication is _____

My patient's ICD-10 diagnosis code is: _____
(See page 9 for list of possible diagnosis codes)

Medical History
☐ No Known Drug Allergies Known Drug Allergies: _____

Transplant History
Has the patient had a kidney transplant? ☐ Yes ☐ No
Date of most recent kidney transplant: _____ (month/year)

VI. Current Medications (to be completed by healthcare provider)
Current Therapy
☐ FABHALTA[®] (Iptacopan) ☐ C5 inhibitors ☐ Immunosuppressants ☐ Rituximab
Other Current Medications: _____

VII. Prescriber Information (to be completed by healthcare provider)

Last Name: _____
First Name: _____ MI: _____
Office/Clinic/Facility Name: _____
NPI Number: _____
State License Number: _____
Practice Street Address: _____
City: _____ State: _____ ZIP Code: _____
Phone: _____
Fax: _____

Primary Office Contact
Office Contact Name: _____
Contact Phone: _____
Contact Email: _____
Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax

Secondary Office Contact
Office Contact Name: _____
Contact Phone: _____
Contact Email: _____
Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on pages 10-11, and the full Prescribing Information, and Medication Guide.

Apellis 2

Please see full Important Safety Information on pages 8-9 and accompanying full Prescribing Information, including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and Medication Guide.

Page 3: Prescription Selection

Section VIII: Prescription for EMPAVELI[®] (pegcetacoplan)

Select the patient-specific orders for EMPAVELI. Please note for patients under the age of 18, weight-based dosing is recommended.

Refills

Please enter the refill amount as this allows PANTHERx to continue to fill the prescription.

Shipment

Please make sure to check the box that best fits your patient's situation.



Prescriber Signature Required

ApellisAssist[™] Patient Name: _____ Date of Birth: _____

HEALTHCARE PROVIDER FORM
Phone: 1-866-MY-APL-ASSIST | (1-866-692-7527) Fax: 1-888-754-1285

VIII. Prescription for EMPAVELI[®] (pegcetacoplan) (to be completed by healthcare provider)

Rx: EMPAVELI 1080 mg/20 mL vial

This prescription will be filled by PANTHERx[®] Specialty Pharmacy.

Patient weight (for pediatric patients between 12 and less than 18 years of age): _____ kg ☐ lbs Anticipated Start Date: _____

Directions for patients to infuse subcutaneously (please check one of the four boxes below):		
☐	Adult patients (18 years and older) or Pediatric patients (12 years of age and older) ≥ 50 kg	Infuse 1080 mg (20 mL) subcutaneously twice weekly as directed
☐	Pediatric patients (12 years of age and older) 35 to < 50 kg	First dose: Infuse 648 mg (12 mL) subcutaneously as directed Second dose: Infuse 810 mg (15 mL) subcutaneously as directed Maintenance dose: Infuse 810 mg (15 mL) subcutaneously twice weekly as directed
☐	Pediatric patients (12 years of age and older) < 35 kg	First dose: Infuse 540 mg (10 mL) subcutaneously as directed Second dose: Infuse 540 mg (10 mL) subcutaneously as directed Maintenance dose: Infuse 648 mg (12 mL) subcutaneously twice weekly as directed
☐	Other	First dose: Infuse: _____ mg subcutaneously as directed Second dose: Infuse: _____ mg subcutaneously as directed Maintenance dose: Infuse: _____ mg subcutaneously as directed thereafter SIG: _____

Vials: ☐ 8 or ☐ _____

Refills: _____

Dispense administration device and ancillary supplies necessary to administer medication.

SHIP AS SOON AS AUTHORIZED - NO PRESCRIBER HOLD

☐ I have reviewed the EMPAVELI vaccination requirements, [Vaccine Recommendations on page 8](#), and my patient's vaccination history and certify that my patient has been or will be vaccinated or will receive prophylactic antibiotic prior to beginning treatment with EMPAVELI and **PANTHERx is authorized to dispense as soon as possible.**

OR

HOLD SHIPMENT UNTIL VACCINATION IS CONFIRMED - CONTACT OFFICE PRIOR TO DISPENSE

☐ I have reviewed the EMPAVELI vaccination requirements, [Vaccine Recommendations on page 8](#), and my patient's vaccination history and certify that my patient has been or will be vaccinated or will receive prophylactic antibiotic prior to beginning treatment with EMPAVELI. **I request that the EMPAVELI shipment should be held, with additional follow-up to your office to confirm appropriate timing for dispense and allow for administration of missing vaccinations, prescribed herein or to alternate provider.**

Prescriber Signature (stamps not accepted)

Dispense as written: _____ Date: _____

Substitution permissible: _____ Date: _____

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on [pages 10-11](#), and the full [Prescribing Information](#), and [Medication Guide](#).

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Please see full Important Safety Information on [pages 8-9](#) and accompanying full [Prescribing Information](#), including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and [Medication Guide](#).

Pages 4 & 5: Patient Vaccine History & Prescriptions

Section IX: Vaccine History

Please fill out the Vaccination History to the best of your ability. If you or your patient require vaccination support, please check the box and a dedicated ApellisAssist team member will follow up with you and/or your patient.

ApellisAssist[®] Patient Name: _____ Date of Birth: _____

HEALTHCARE PROVIDER FORM
Phone: 1-866-MY-APL-ASSIST | (1-866-692-7527) Fax: 1-888-754-1285

IX. Patient Vaccine History (to be completed by healthcare provider)

The ApellisAssist program offers education and support specific to the vaccination requirements outlined in the EMPAVELI REMS. The EMPAVELI REMS requires the dispensing pharmacy to assess a patient's vaccination history by contacting the prescriber and documenting the findings prior to dispensing. Completing the patient's vaccination history will reduce the need for additional follow-up with your office to meet this pharmacy EMPAVELI REMS requirement.

In the Vaccination History box below, document the brand administered and administration date of each dose (if known) of the indicated vaccine.

☐ Check here if your patient will need vaccination support to help comply with REMS requirements. A dedicated ApellisAssist team member will follow up with you and/or your patient and provide more information.

Vaccination History	
ACIP Recommendation for Patients With Complement Deficiency to Begin Treatment With EMPAVELI (page 8) Current ACIP recommendations available at: https://www.cdc.gov/vaccines/hcp/immunization-schedules/adult-medical-condition.html	
Pneumococcal PCV21, PCV20, PCV15, PPSV23 & PCV13 ☐ History Unknown ☐ Vaccine Not Received	Brand administered: ☐ Capvaxim [®] (PCV21) ☐ Prevnar 20 [®] (PCV20) ☐ Vaxneuvance [®] (PCV15) ☐ Pneumovax [®] (PPSV23) ☐ Prevnar 13 [®] (PCV13) Please enter all relevant dose dates below: Dose #1 Date: _____ Dose #2 Date: _____ Dose #3 Date: _____ Dose #4 Date: _____
Meningococcal Conjugate (MenACWY) ☐ History Unknown ☐ Vaccine Not Received	Brand administered: ☐ Menactra [®] (MenACWY-D) ☐ Menveo [®] (MenACWY-CRM) ☐ MenQuadfi [®] (MenACWY-TT) ☐ Penbraya [™] (MenACWY-TT/MenB-FHbp) Please enter all relevant dose dates below: Dose #1 Date: _____ Dose #2 Date: _____ Booster Date: _____
Serogroup B Meningococcal (MenB) ☐ History Unknown ☐ Vaccine Not Received	Brand administered: ☐ Bexsero [®] (MenB-4C) ☐ Trumenb [®] (MenB-FHbp) ☐ Penbraya [™] (MenACWY-TT/MenB-FHbp) Please enter all relevant dose dates below: Dose #1 Date: _____ Dose #2 Date: _____ Dose #3 Date: _____ Booster Date: _____
If prophylactic antibiotic was prescribed with EMPAVELI outside of this form, please indicate anticipated antibiotic start date. Date: _____	

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on pages 10-11, and the full Prescribing Information, and Medication Guide.

Apellis 4

Section X: Vaccine Prescriptions (if necessary)

If your patient needs any vaccinations, PANTHERx can assist as part of the vaccination support program. Please fill in the prescription information for your patient and PANTHERx may coordinate administration based on the patient's location and insurance.

ApellisAssist[®] Patient Name: _____ Date of Birth: _____

HEALTHCARE PROVIDER FORM
Phone: 1-866-MY-APL-ASSIST | (1-866-692-7527) Fax: 1-888-754-1285

X. Patient Vaccine Prescription(s) (to be completed by healthcare provider)

Submitting an order for vaccination(s) will reduce the need for additional follow-up with your office.

If you submit an order for vaccinations for your patient in the table below, ApellisAssist will coordinate the administration of vaccines directly with the patient based on the location and insurance coverage of the patient. ApellisAssist will also coordinate any provided prescription for prophylactic antibiotics with the patient's local pharmacy. Administer recommended vaccines if vaccination history is incomplete or unknown.

Vaccine Prescriptions (if necessary)	
ACIP Recommendation for Patients With Complement Deficiency to Begin Treatment With EMPAVELI (page 8) Current ACIP recommendations available at: https://www.cdc.gov/vaccines/hcp/immunization-schedules/adult-medical-condition.html	
Pneumococcal PCV21, PCV20, PCV15, PPSV23 & PCV13 ☐ Capvaxim [®] (PCV21) ☐ Prevnar 20 [®] (PCV20) ☐ Vaxneuvance [®] (PCV15) ☐ Pneumovax [®] (PPSV23) ☐ Prevnar 13 [®] (PCV13) SIG: Administer intramuscularly as directed Other: _____ Quantity x 1 Refills: _____	
Meningococcal Conjugate (MenACWY) ☐ Menactra [®] (MenACWY-D) ☐ Menveo [®] (MenACWY-CRM) ☐ MenQuadfi [®] (MenACWY-TT) ☐ Penbraya [™] (MenACWY-TT/MenB-FHbp) SIG: Administer intramuscularly as directed Other: _____ Quantity x 1 Refills: _____	
Serogroup B Meningococcal (MenB) ☐ Bexsero [®] (MenB-4C) ☐ Trumenb [®] (MenB-FHbp) ☐ Penbraya [™] (MenACWY-TT/MenB-FHbp) SIG: Administer intramuscularly as directed Other: _____ Quantity x 1 Refills: _____	
Prescriber Signature (stamps not accepted) Dispense as written: _____ Date: _____ Substitution permissible: _____ Date: _____ Prescriber NPI: _____	

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on pages 10-11, and the full Prescribing Information, and Medication Guide.

Apellis 5

Please see full Important Safety Information on pages 8-9 and accompanying full Prescribing Information, including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and Medication Guide.

 EMPAVELI[®]
(pegcetacoplan) injection
1080 mg/20 mL solution

 Prescriber Signature Required

	Patient Name: _____	Date of Birth: _____ HEALTHCARE PROVIDER FORM Phone: 1-866-MY-APL-ASSIST [x] 1-866-692-7527 Fax: 1-866-754-1285
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XI. Prescriber Authorization for Injection-Site Reaction Management Plan (Optional)

(To be completed by healthcare provider)

Injection-site reactions (ISRs) are one of the most common side effects with EMPAVELL. ISRs are not the only adverse reactions (ARs) a patient may experience with EMPAVELL. For a complete list of ARs associated with EMPAVELL, please refer to the full [Prescribing Information](#).

The following are instructions you may have provided to your patients regarding treatment of common ISRs.

Should you choose to review these instructions with your patient, please select from the below options to indicate these are the instructions your patient should follow in the event of an ISR.

In the event of an AR, Care Educators follow Empiris protocols associated with AR reporting and instruct patients to call their doctors.

I (physician) authorize the following checked items for my patient regarding treatment for local ISRs:

- ☐ OTC analgesics, gentle massage, or warm compress for pain
- ☐ Cold compress for minor bruising and redness
- ☐ OTC antihistamine or topical steroid for itching
- ☐ Warm compresses or gentle massage for swelling (5-10 min)
- ☐ OTC barrier film wipe for skin irritation (apply in a circular motion leaving the center untouched. Do not inject through the film)
- ☐ OTC silicone-based adhesive remover
- ☐ Other_____

Patients will be instructed to call their doctor if a local reaction:

- ☐ Does not go away after 7 days
- ☐ Is severe: blisters, redness that is larger than 2 inches, or severe bruising, bleeding, pain, or itching
- ☐ Worsens after each injection; OR
- ☐ Other: _____

XII. Prescriber Declaration and Authorization: HCP Signature Required

(To be completed by healthcare provider)

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 an Apellis medication. The patient support and resources include, but are not limited to, providing (i) reimbursement and financial assistance information; (ii) access to the Apellis medication; and (iii) disease and medication-related educational resources and communications, including self-administration training by an Apellis Care Educator ("Patient Resources").

By signing below, I certify that:

- The information contained in this form is complete and accurate to the best of my knowledge.
- 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 an Apellis medication was based solely on my clinical determination and medical necessity, and will not seek reimbursement for any medication or Patient Resource provided by or through Apellis from any government program or third-party insurer.
- I authorize Apellis to provide Patient Resources to my patient, including training by a Care Educator on administration of the medication. I understand that this does not include individual treatment or medical advice to my patient, and I do 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 Care Educator training 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.

☐ I have reviewed the optional ISR management plan in section XI, Prescriber Authorization for Injection-Site Reaction Management Plan, and authorizes a Care Educator to train my patient on Injection-Site Reaction (ISR) management plan per my designated instructions as indicated in XI, Prescriber Authorization for Injection-Site Reaction Management Plan.

Prescriber Signature (stamps not accepted) _____

Sign here: _____

Date: _____

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on pages 10-11, and the full [Prescribing Information](#), and [Medication Guide](#).

Apellis

Pages 7-11: Consent Terms, Vaccination Recommendations, & Important Safety Information

[illegible]

6



Complete the EMPAVELI Start Form
online at **Apellis.iAssist.com**

OR



Download the Start Form at
EMPAVELIHCP.com and fax
completed form to 1-888-754-1285

Thank you for your form submission, which has been captured on the following date: _____

Apellis*Assist*[®]

HEALTHCARE PROVIDER FORM
Phone: 1-866-MY-APL-ASSIST | (1-866-692-7527)
Fax: 1-888-754-1285

**EMPAVELI[®] (pegcetacoplan)
Nephrology Start Form**

1. Visit EMPAVELIREMS.com to get certified in the EMPAVELI REMS before writing your first prescription. You will only need to register once. REMS certification is required to dispense EMPAVELI to your patient.
2. Review the REMS requirements with your patient.
3. Have the patient or caregiver sign the Patient Consents section, section II below.
4. Complete all remaining fields on pages 1-6.

I. Patient Information *(to be completed by patient or patient caregiver)*

First Name: _____ Mi: _____ Email: _____
Last Name: _____ Preferred Phone: _____
Date of Birth (mm/dd/yyyy): _____ ☐ Allow voicemail messages containing detailed medical information on this phone number
Sex: ☐ Male ☐ Female Alternative Phone: _____
Street Address: _____ ☐ Allow voicemail messages containing detailed medical information on this phone number
City: _____ State: _____ ZIP Code: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

II. Patient Consents *(to be completed by patient or patient's caregiver; caregiver signature is required for patients under the age of 18)*
Prior to completing the EMPAVELI Start Form, please share the Enrollment and Privacy Terms ([page 2](#)) with your patient or their caregiver and have them complete sections A, B, and C below.

A. HIPAA Authorization *(see section A on page 7)*
By signing this form, I attest that I have read and agree to the HIPAA Authorization on page 7, section A. I understand I am entitled to a copy of this signed authorization.
Signature of patient or caregiver: _____ Date: _____

B. Consent to Enroll in Patient Support through ApellisAssist[®] and Receive Self-Administration Training and Education *(see section B on page 7)*
I have read and I understand the Patient Support and Self-Administration Training and Education enrollment terms on page 7, section B and agree to the terms.
Signature of patient or caregiver: _____ Date: _____

C. Marketing Consent (optional)
☐ I consent to receive marketing communications from Apellis Pharmaceuticals, Inc., about its programs, products, services, and research opportunities. I understand I can opt-out anytime and review Apellis's privacy practices at <https://apellis.com/privacy-policy/>.

III. Caregiver Information *(required for patients under the age of 18)*
Caregiver First Name: _____ Last Name: _____
Preferred Phone: _____ Email: _____
What is the caregiver's relationship to the patient? ☐ Parent/Legal Guardian ☐ Spouse ☐ Other: _____

Please see full Important Safety Information, including Boxed WARNING regarding risk of serious infections, on pages 10-11, and the full Prescribing Information, and Medication Guide.

Apellis 1

Please see full Important Safety Information on [pages 8-9](#) and accompanying full [Prescribing Information](#), including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and [Medication Guide](#).

INDICATION

EMPAVELI[®] (pegcetacoplan) is indicated for the treatment of adult and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria.

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS INFECTIONS CAUSED BY ENCAPSULATED BACTERIA

EMPAVELI, a complement inhibitor, increases the risk of serious infections, especially those caused by encapsulated bacteria, such as *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B. Life-threatening and fatal infections with encapsulated bacteria have occurred in patients treated with complement inhibitors. These infections may become rapidly life-threatening or fatal if not recognized and treated early.

- Complete or update vaccination for encapsulated bacteria at least 2 weeks prior to the first dose of EMPAVELI, unless the risks of delaying therapy with EMPAVELI outweigh the risks of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria in patients receiving a complement inhibitor.
- Patients receiving EMPAVELI are at increased risk for invasive disease caused by encapsulated bacteria, even if they develop antibodies following vaccination. Monitor patients for early signs and symptoms of serious infections and evaluate immediately if infection is suspected.

Because of the risk of serious infections caused by encapsulated bacteria, EMPAVELI is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the EMPAVELI REMS.

CONTRAINDICATIONS

- Hypersensitivity to pegcetacoplan or to any of the excipients
- For initiation in patients with unresolved serious infection caused by encapsulated bacteria including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B

WARNINGS AND PRECAUTIONS

Serious Infections Caused by Encapsulated Bacteria

EMPAVELI, a complement inhibitor, increases a patient's susceptibility to serious, life-threatening, or fatal infections caused by encapsulated bacteria including *Streptococcus pneumoniae*, *Neisseria meningitidis* (caused by any serogroup, including non-groupable strains), and *Haemophilus influenzae* type B. Life-threatening and fatal infections with encapsulated bacteria have occurred in both vaccinated and unvaccinated patients treated with complement inhibitors. The initiation of EMPAVELI treatment is contraindicated in patients with unresolved serious infection caused by encapsulated bacteria.

Complete or update vaccination against encapsulated bacteria at least 2 weeks prior to administration of the first dose of EMPAVELI, according to the most current ACIP recommendations for patients receiving a complement inhibitor. Revaccinate patients in accordance with ACIP recommendations considering the duration of therapy with EMPAVELI. Note that, ACIP recommends an administration schedule in patients receiving complement inhibitors that differs from the administration schedule in the vaccine prescribing information. If urgent EMPAVELI therapy is indicated in a patient who is not up to date with vaccines against encapsulated bacteria according to ACIP recommendations, provide the patient with antibacterial drug prophylaxis and administer these vaccines as soon as possible. The benefits and risks of treatment with EMPAVELI, as well as the benefits and risks of antibacterial drug prophylaxis in unvaccinated or vaccinated patients, must be considered against the known risks for serious infections caused by encapsulated bacteria.

Vaccination does not eliminate the risk of serious encapsulated bacterial infections, despite development of antibodies following vaccination. Closely monitor patients for early signs and symptoms of serious infection and evaluate patients immediately if an infection is suspected. Inform patients of these signs and symptoms and instruct patients to seek immediate medical care if these signs and symptoms occur. Promptly treat known infections. Serious infection may become rapidly life-threatening or fatal if not recognized and treated early. Consider interruption of EMPAVELI in patients who are undergoing treatment for serious infections.

EMPAVELI is available only through a restricted program under a REMS.

Please see full Important Safety Information on pages 8-9, and accompanying full Prescribing Information, including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and Medication Guide.

IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

EMPAVELI REMS

EMPAVELI is available only through a restricted program under a REMS called EMPAVELI REMS, because of the risk of serious infections caused by encapsulated bacteria. Notable requirements of the EMPAVELI REMS include the following:

Under the EMPAVELI REMS, prescribers must enroll in the program. Prescribers must counsel patients about the risks, signs, and symptoms of serious infections caused by encapsulated bacteria, provide patients with the REMS educational materials, ensure patients are vaccinated against encapsulated bacteria at least 2 weeks prior to the first dose of EMPAVELI, prescribe antibacterial drug prophylaxis if patients' vaccine status is not up to date and treatment must be started urgently, and provide instructions to always carry the Patient Safety Card both during treatment, as well as for 2 months following last dose of EMPAVELI. Pharmacies that dispense EMPAVELI must be certified in the EMPAVELI REMS and must verify prescribers are certified.

Further information is available at www.empavelirems.com or 1-888-343-7073.

Infusion-Related Reactions

Systemic hypersensitivity reactions (eg, facial swelling, rash, urticaria, pyrexia) have occurred in patients treated with EMPAVELI, which may resolve after treatment with antihistamines. Cases of anaphylaxis leading to treatment discontinuation have been reported. If a severe hypersensitivity reaction (including anaphylaxis) occurs, discontinue EMPAVELI infusion immediately, institute appropriate treatment, per standard of care, and monitor until signs and symptoms are resolved.

Interference with Laboratory Tests

There may be interference between silica reagents in coagulation panels and EMPAVELI that results in artificially prolonged activated partial thromboplastin time (aPTT); therefore, avoid the use of silica reagents in coagulation panels.

ADVERSE REACTIONS

Most common adverse reactions in adult and pediatric patients 12 years of age and older with C3G or primary IC-MPGN (incidence $\geq 10\%$) were infusion-site reactions, pyrexia, nasopharyngitis, influenza, cough, and nausea.

USE IN SPECIFIC POPULATIONS

Females of Reproductive Potential

EMPAVELI may cause embryo-fetal harm when administered to pregnant women. Pregnancy testing is recommended for females of reproductive potential prior to treatment with EMPAVELI. Advise female patients of reproductive potential to use effective contraception during treatment with EMPAVELI and for 40 days after the last dose.

Please see accompanying full Prescribing Information, including Boxed WARNING regarding serious infections caused by encapsulated bacteria, and Medication Guide.

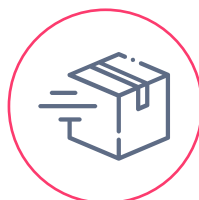


The ApellisAssist Program is designed to **help patients along their treatment journey**.

We provide patients with a **comprehensive support system** inclusive of insurance support, financial assistance for eligible patients, education, training, and product support.



Insurance support



Medication and supply ordering



Financial assistance*



Self-administration training



Vaccine coordination



Disease state education

Call the ApellisAssist team at
1-866-MY-APL-ASSIST (1-866-692-7527)
8 AM-8 PM ET, Monday-Friday

*For eligible patients

Please see full Important Safety Information on pages 8-9 and accompanying full Prescribing Information, including **Boxed WARNING** regarding serious infections caused by encapsulated bacteria, and Medication Guide.



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