Start Form

For Healthcare Providers

(Sections 6 – 8 to be read and completed by **Healthcare Provider**)

amvuttra (vutrisiran) injection 25 mg/0.5 mL

6. Prescriber Information

Name (First, Last):	Office/Clinic/Institution Name: Abington Neurological Associates	Specialty: Neurology

Office/Clinic/Institution Street Address: 1151 Old York Road, Suite 200	City: Abington	State: PA

Zip: 19001	Phone: 215-957-9250	Fax: 215-957-9254	National Provider ID (NPI) #:	State License Number:	Tax ID #:

Office Contact Name:	Phone:	Email:

Product Acquisition:

- ☐ Specialty Pharmacy:
  - ☐ Accredo Health Group Inc. ☐ CVS Specialty ☐ Orsini ☐ PANTHERx ☐ No preference
- ☐ Specialty Distributor (McKesson Specialty or McKesson Plasma and Biologics)
- ☐ Unknown

Anticipated First Treatment Date:

7. AMVUTTRA® (vutrisiran) Prescription (This is a prescription; a prescriber's signature and date are required.)

Patient Name (First, MI, Last):	Patient Date of Birth: Month/Day/Year:

Primary Diagnosis Code:

AMVUTTRA injection for subcutaneous use, 25 mg/0.5 mL	☐ AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months	Quantity: ☐ One prefilled syringe	Refills: ☐ Refill x 3 ☐ Other _____

Any known allergies? ☐ Yes ☐ No If yes, please list:

List or attach a list of concomitant medications:

Special Instructions:

☐ **I confirm that my patient is being prescribed AMVUTTRA for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults**

I authorize Alnylam to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy. I will comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc.

X	
Prescriber Signature (No Stamps) Dispense as Written	Date
X	
Prescriber Signature (No Stamps) Substitution Permitted	Date

Desired Site of Care _____

- ☐ Home Injection (see patient home address)
- ☐ Alternate Medical Facility (provide facility name and address)
- ☐ Physician Office (see provider office address)
- ☐ Facility to Home (first dose at facility; remainder at home)

Facility Name/Address _____

▷ Continue to page 4 to complete the prescriber portion of the Start Form

Alnylam ASSIST

Start Form

amvuttra (vutrisiran) injection 25 mg/0.5 mL

8. Prescriber Declaration

By signing below, I certify that:

- The information contained in this form is complete and accurate to the best of my knowledge
- I understand that Alnylam is not responsible for filing claims or submitting other information to my patient's insurer and that the information provided by Alnylam Assist™ is educational in nature
- I understand that my patient may authorize Alnylam Assist to provide Patient Support. I understand that this program does not include individual treatment or medical advice to the patient, and it does not replace the medical treatment and care provided by me as the patient's healthcare provider
- I further certify that I understand that any support provided by Alnylam Assist 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 AMVUTTRA® (vutrisiran) or any other Alnylam product, and any decision to prescribe AMVUTTRA was, and in the future will be, based solely on my determination of medical necessity
- I have obtained the required authorizations from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to Alnylam Assist

X _____ _____

Prescriber signature (stamps not acceptable) Date

Indication

AMVUTTRA® (vutrisiran) is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

Important Safety Information

Reduced Serum Vitamin A Levels and Recommended Supplementation

AMVUTTRA treatment leads to a decrease in serum vitamin A levels. Supplementation at the recommended daily allowance (RDA) of vitamin A is advised for patients taking AMVUTTRA. Higher doses than the RDA should not be given to try to achieve normal serum vitamin A levels during treatment with AMVUTTRA, as serum vitamin A levels do not reflect the total vitamin A in the body.

Patients should be referred to an ophthalmologist if they develop ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness).

Adverse Reactions

The most common adverse reactions that occurred in patients treated with AMVUTTRA were pain in extremity (15%), arthralgia (11%), dyspnea (7%), and vitamin A decreased (7%).

For additional information about AMVUTTRA please see the full Prescribing Information.

Fax the completed Start Form to 1-833-256-2747 | Call Alnylam Assist at 1-833-256-2748 8AM–6PM, Monday–Friday | For more information visit www.AlnylamAssist.com

Alnylam PHARMACEUTICALS

Alnylam ASSIST