

Start Form

- ▷ Before submitting the Start Form to Alnylam Assist™, patient **and** prescriber signatures are required
- ▷ **Patients currently prescribed an Alnylam medicine who are enrolled in Alnylam Assist do not need to complete Sections 1 – 5**

For Patients Alnylam Assist Enrollment

(Sections 1 – 5 to be read and completed by **Patient** or **Patient's Authorized Representative**)

The purpose of this form is to permit Alnylam Assist participants to receive additional information and support ("Patient Support") from Alnylam Pharmaceuticals, Inc., its affiliates, representatives, agents, and contractors ("Alnylam"). Alnylam Assist provides Patient Support to eligible patients who have been prescribed an Alnylam medicine. This includes: (1) providing reimbursement and financial support to eligible patients (such as investigating your insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance); (2) working with you and your provider to fill your prescription; and (3) providing you with disease and medication-related educational resources and communications. Your authorization in this form will relate to information and support with respect to any Alnylam medicine you have been prescribed or may be prescribed in the future.

Please read this form carefully and ask any questions that you may have before signing.

1. Patient Information

Name (First, MI, Last):

Date of Birth: Month/Day/Year

Email:

Street Address:

City:

State:

Zip:

Preferred Phone Number: ☐ **Okay to leave voicemail**

Alternative Phone Number (if available): ☐ **Okay to leave voicemail**

Caregiver Name (optional):

Caregiver Relationship to Patient (optional):

Caregiver Phone (optional): ☐ **Okay to leave voicemail**

Caregiver Email (optional):

Language translation? ☐ Yes, translation needed ☐ No
If yes, please indicate language:

2. Insurance Information

Attach a copy of both sides of your medical INSURANCE and PRESCRIPTION insurance cards
☐ **Check if you do not have insurance**

Primary Insurance Provider:

Employer Name:

Policy Number:

Group Number:

Policyholder Name (First, MI, Last), if other than the patient:

Policyholder Date of Birth: Month/Day/Year

Insurance Phone:

Pharmacy Plan Provider (if applicable):

Policy Number:

Group Number:

Rx Bin Number:

Rx PCN Number:

Policyholder Name (First, MI, Last), if other than the patient:

Policyholder Date of Birth: Month/Day/Year

Insurance Phone:

Secondary Insurance Provider (if applicable):

Employer Name:

Policy Number:

Group Number:

Policyholder Name (First, MI, Last), if other than the patient:

Policyholder Date of Birth: Month/Day/Year

Insurance Phone:

▷ Continue to page 2 to complete the patient portion of the Start Form

Please see **Important Safety Information** on page 4 and full **Prescribing Information**.

Start Form



3. Authorization to Share Protected Health Information

By signing below, I authorize my healthcare providers, including my physicians and pharmacies (“My Providers”) and my health insurance plan (“My Plan”) to share my medical information (such as information about my diagnosis, prescriptions, and treatment) and my insurance information (“My Information”) with Alnylam so that Alnylam can provide Patient Support. I authorize My Providers to use My Information to provide me with certain offerings related to my treatment and any Alnylam medicine My Providers may prescribe for me at any time. I understand that my pharmacy will receive payment from Alnylam for disclosing My Information to Alnylam. I understand that once My Information has been disclosed, federal privacy laws may no longer protect the information. However, I understand that Alnylam agrees to protect My Information by using and disclosing it only for purposes described in this Authorization or as required by law. I understand that I may refuse to sign this Authorization, and that my treatment, insurance enrollment, and eligibility for insurance benefits are not conditioned upon signing this Authorization.

I also understand, however, that refusing to sign this Authorization means that I may not participate in Alnylam Assist™ and may not be able to take advantage of other offerings by Alnylam. I may cancel or revoke this Authorization at any time by mailing a letter to Privacy Officer at Alnylam, Attn: Legal Department, 675 West Kendall Street, Cambridge, MA 02142 or by sending an email to privacy@alnylam.com. I understand that if I revoke this Authorization, My Providers and Alnylam will stop using and sharing My Information under this Authorization, but my revocation will not affect uses and disclosures of My Information prior to my revocation in reliance upon this Authorization.

This Authorization expires ten (10) years from the date signed below, or earlier if required by state or local law, unless I revoke it before then. I understand that I may receive a copy of this Authorization.

Print Patient or Authorized Patient Representative Name

Relationship to Patient

X

Signature of Patient or Authorized Patient Representative

Date

4. Authorization for Alnylam Assist and Communications

By signing below, I confirm I would like to enroll in the Alnylam Assist program and authorize Alnylam to provide me with Patient Support. I understand that Alnylam Assist is an optional program.

I agree that Alnylam may use My Information and share it with My Providers or My Plan in connection with providing the Patient Support, administering the Alnylam Assist program, or as otherwise required by Alnylam to meet its legal obligations. For example, Alnylam may communicate with me (such as by mail, phone, email, and/or text message) or my caregiver, use My Information to tailor the Alnylam Assist-related communications to my needs, and share information with My Providers about dispensing Alnylam medicine to me. I understand that Alnylam may de-identify My Information, combine it with information about other patients, and use the resulting information for Alnylam’s business purposes.

Print Patient or Authorized Patient Representative Name

Relationship to Patient

X

Signature of Patient or Authorized Patient Representative

Date

5. Opt-in to Receive Marketing Communications (optional)

☐ By checking this box, I authorize Alnylam, and companies working with Alnylam, to contact me by mail, email, fax, and/or telephone regarding marketing and promotional communications, customer surveys, or for market research surveys. **I understand that I am not required to provide this consent as a condition of receiving any Alnylam medicine or services from Alnylam.**

Please see [Important Safety Information](#) on page 4 and full [Prescribing Information](#).

