

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.

X

Signature of Patient or Authorized Patient Representative

Print Patient or Authorized Patient Representative Name

Date

Relationship to Patient

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.

X

Signature of Patient or Authorized Patient Representative

Print Patient or Authorized Patient Representative Name

Date

Relationship to Patient

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.

Start Form

For Healthcare Providers

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



6. Prescriber Information

Name (First, Last):		Office/Clinic/Institution Name:		Specialty:	
Office/Clinic/Institution Street Address:			City:		State:
Zip:	Phone:	Fax:	National Provider ID (NPI) #:	State License Number:	Tax ID #:
Office Contact Name:		Phone:		Email:	
Product Acquisition: <input type="checkbox"/> Specialty Pharmacy: <input type="checkbox"/> Accredo Health Group Inc. <input type="checkbox"/> CVS Specialty <input type="checkbox"/> Orsini <input type="checkbox"/> PANTHERx <input type="checkbox"/> No preference <input type="checkbox"/> Specialty Distributor (McKesson Specialty or McKesson Plasma and Biologics) <input type="checkbox"/> 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	<input type="checkbox"/> AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months	Quantity: <input type="checkbox"/> One prefilled syringe	Refills: <input type="checkbox"/> Refill x 3 <input type="checkbox"/> 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

<input type="checkbox"/> Home Injection (see patient home address)	<input type="checkbox"/> Physician Office (see provider office address)
<input type="checkbox"/> Alternate Medical Facility (provide facility name and address)	<input type="checkbox"/> 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

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

Start Form



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



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