Start Form

amvuttra (vutrisiran) injection 25 mg/0.5 mL

- Before submitting the Start Form to Alnylam Assist®, **both patient and prescriber signatures are required**
- Patients prescribed an Alnylam medicine who are enrolled in Alnylam Assist® do not need to complete Sections 1 and 2
- **Complete and sign the form**, then fax pages 1 and 3 to 1-833-256-2747

For Patients

Alnylam Assist® Enrollment

Sections 1 and 2 to be completed and signed 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; (3) providing you with disease and medication-related educational resources and communications; and (4) contacting you to participate in disease and medication-related market research panels or surveys. 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 (MM/DD/YYYY):	
Email:	Language Translation? ☐ Yes, translation needed ☐ No If yes, please indicate language:		
Street Address:	City:	State:	ZIP Code:
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 Number (optional): ☐ **Okay to leave voicemail**		Caregiver Email (optional):	

I have read and agree to the Patient Authorization and Support Program Authorization on page 2

SIGN HERE

Patient/Legal Representative Signature	**Date (MM/DD/YYYY)**	**Printed Name/Relationship to Patient (if applicable)**

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 (MM/DD/YYYY):		Insurance Phone Number:
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 (MM/DD/YYYY):		Insurance Phone Number:
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 (MM/DD/YYYY):		Insurance Phone Number:

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3. Authorization to Share Protected Health Information

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 on page 1, 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. *For information about how your personal data are processed as a part of our program, please visit www.alnylampolicies.com/privacy.*

4. Authorization for Alnylam Assist® and Communications

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. I understand that the administration of the program might involve the use of artificial intelligence technologies to process My Information and that Alnylam and their third-party vendors might de-identify My Information for machine learning purposes.

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Please ensure your patient signs page 1. Without a patient signature, we are unable to process this form

For Healthcare Providers

Sections 5-7 to be completed and signed by Healthcare Provider

5. Prescriber Information

Name (First, Last):		Office/Clinic/Institution Name:		Specialty:
Office/Clinic/Institution Street Address:		City:	State:	ZIP Code:
Phone Number:	Fax Number:	National Provider ID (NPI) #:	State License Number:	Tax ID Number:
Office Contact Name:		Phone Number:	Email:	
Referring Physician:			Anticipated First Treatment Date:	

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

Patient Name (First, MI, Last):		Patient Date of Birth (MM/DD/YYYY):	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**
☐ **Patient was previously enrolled in a vutrisiran clinical trial. Last vutrisiran injection date:** _____

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. By signing below, I certify that (1) the information contained in this form is complete and accurate to the best of my knowledge; (2) I have obtained the required authorizations from my patient to release the information included in this form and/or other patient information relating to my patient's treatment to Alnylam Assist®; and (3) I have read and agree to the Prescriber Declaration on page 4.

SIGN HERE

Prescriber Signature (No Stamps) Dispense as Written | **Date (MM/DD/YYYY)**

SIGN HERE

Prescriber Signature (No Stamps) Substitution Permitted | **Date (MM/DD/YYYY)**

Desired Site of Care

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

Facility Name/Address:			Contact Name:	
Phone Number:	Fax Number:	Email:	NPI #:	Tax ID Number:

To search for treatment centers close to your patient, visit **www.amvuttrahcp.com/treatment-center-directory**

Please complete and sign the form, then fax pages 1 and 3 to 1-833-256-2747

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7. Prescriber Declaration

By signing on page 3, I certify that: 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 also 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 authorization to allow Alnylam Assist® to contact the patient or caregiver for a signed Patient Authorization, if not already included.

Once you and your patient have completed and signed the form, fax pages 1 and 3 to

1-833-256-2747

Call Alnylam Assist® at 1-833-256-2748
8AM–6PM, Monday–Friday
For more information, visit **www.AlnylamAssist.com/hcp**