Alnylam ASSIST®

AMVUTTRA® (vutrisiran) Start Form

After the decision to prescribe AMVUTTRA has been made, complete pages 1 and 2 of the Start Form to initiate treatment and patient support.

To get your patient started:

STEP 1



Review instructions before completing the Start Form

STEP 2



Be sure the form has the **required patient and prescriber signatures**

STEP 3



Complete, sign, and date the form, then fax pages 1 and 2 to **1-833-256-2747**

YOU CAN ALSO COMPLETE THE AMVUTTRA START FORM ONLINE AT:

www.alnylamassist.com/hcp/amvuttra/webform

amvuttra® (vutrisiran) injection 25 mg/0.5 mL

How to complete the AMVUTTRA® (vutrisiran) Start Form

PATIENT INFORMATION

Customizing product support services is as simple as checking a box

Patients and their doctors can choose any combination of product support options—including Access & Treatment Initiation Support, Affordability & Financial Support, Ongoing Treatment Support, and Patient Education Support—or Full Product Support for comprehensive support.

Insurance Information

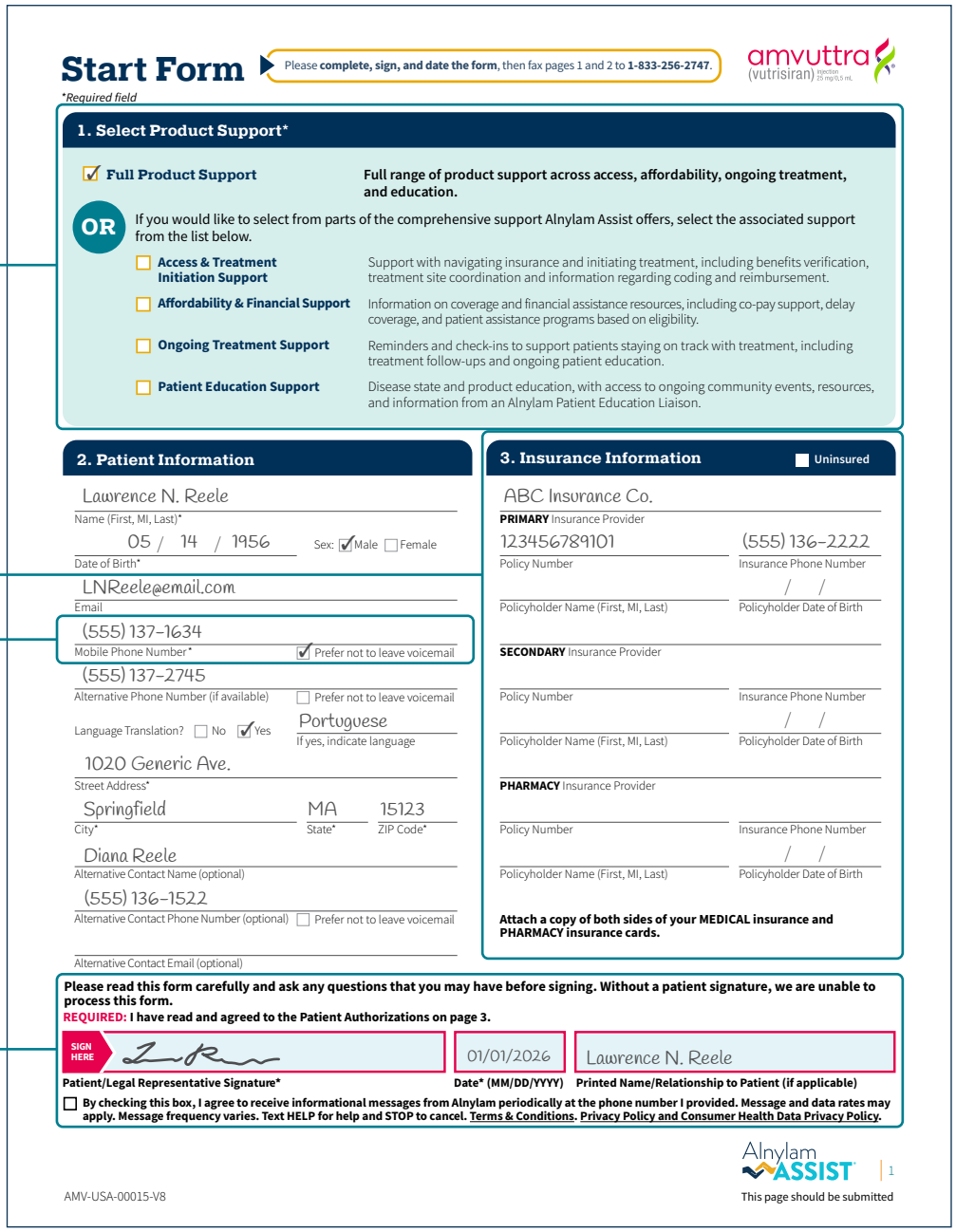
Fill in the provided fields or attach copies of both sides of the patient's insurance and pharmacy insurance cards. Complete insurance information will help our team verify the patient's benefits in a timely manner.

Mobile Phone Number and Voicemail

By checking "Prefer not to leave voicemail", you are declining voicemail messages from Alnylam Assist®. Declining voicemails from Alnylam Assist® may result in delays in starting treatment with AMVUTTRA.

Patient Authorization and Signature

The signature of the patient or authorized patient representative, with the date, is required on page 1 unless the patient is currently prescribed an Alnylam medicine and is already enrolled in Alnylam Assist®. If the patient cannot provide a signature, an Alnylam Case Manager can follow up to obtain patient consent.



Start Form ▶ Please **complete, sign, and date the form**, then fax pages 1 and 2 to **1-833-256-2747**.

amvuttra (vutrisiran)

*Required field

1. Select Product Support*

☑ **Full Product Support** — **Full range of product support across access, affordability, ongoing treatment, and education.**

OR If you would like to select from parts of the comprehensive support Alnylam Assist offers, select the associated support from the list below.

- ☐ **Access & Treatment Initiation Support** — Support with navigating insurance and initiating treatment, including benefits verification, treatment site coordination and information regarding coding and reimbursement.
- ☐ **Affordability & Financial Support** — Information on coverage and financial assistance resources, including co-pay support, delay coverage, and patient assistance programs based on eligibility.
- ☐ **Ongoing Treatment Support** — Reminders and check-ins to support patients staying on track with treatment, including treatment follow-ups and ongoing patient education.
- ☐ **Patient Education Support** — Disease state and product education, with access to ongoing community events, resources, and information from an Alnylam Patient Education Liaison.

2. Patient Information

Lawrence N. Reele — Name (First, MI, Last)*

05 / 14 / 1956 — Date of Birth* — Sex: ☑ Male ☐ Female

LNReele@email.com — Email

(555) 137-1634 — Mobile Phone Number* — ☑ Prefer not to leave voicemail

(555) 137-2745 — Alternative Phone Number (if available) — ☐ Prefer not to leave voicemail

Language Translation? ☐ No ☑ Yes — Portuguese — If yes, indicate language

1020 Generic Ave. — Street Address*

Springfield — City* — MA — State* — 15123 — ZIP Code*

Diana Reele — Alternative Contact Name (optional)

(555) 136-1522 — Alternative Contact Phone Number (optional) — ☐ Prefer not to leave voicemail

Alternative Contact Email (optional)

3. Insurance Information ☐ Uninsured

ABC Insurance Co. — **PRIMARY** Insurance Provider

123456789101 — Policy Number — (555) 136-2222 — Insurance Phone Number

Policyholder Name (First, MI, Last) — / / — Policyholder Date of Birth

SECONDARY Insurance Provider

Policy Number — Insurance Phone Number

Policyholder Name (First, MI, Last) — / / — Policyholder Date of Birth

PHARMACY Insurance Provider

Policy Number — Insurance Phone Number

Policyholder Name (First, MI, Last) — / / — Policyholder Date of Birth

Attach a copy of both sides of your MEDICAL insurance and PHARMACY insurance cards.

Please read this form carefully and ask any questions that you may have before signing. Without a patient signature, we are unable to process this form.

REQUIRED: I have read and agreed to the Patient Authorizations on page 3.

SIGN HERE — Lawrence N. Reele — 01/01/2026 — Lawrence N. Reele

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

☐ **By checking this box, I agree to receive informational messages from Alnylam periodically at the phone number I provided. Message and data rates may apply. Message frequency varies. Text HELP for help and STOP to cancel. Terms & Conditions. Privacy Policy and Consumer Health Data Privacy Policy.**

Alnylam ASSIST® 1

AMV-USA-00015-V8

This page should be submitted

How to complete the AMVUTTRA® (vutrisiran) Start Form

HEALTHCARE PROVIDER INFORMATION

Prescriber Authorization

By submitting this form you are certifying items (1), (2), and (3).

Priority Fields

Please ensure Name, Office, Tax ID, NPI Number, Phone, Street Address, City, State and ZIP fields are completed. If these fields are incomplete, the Start Form cannot be processed.

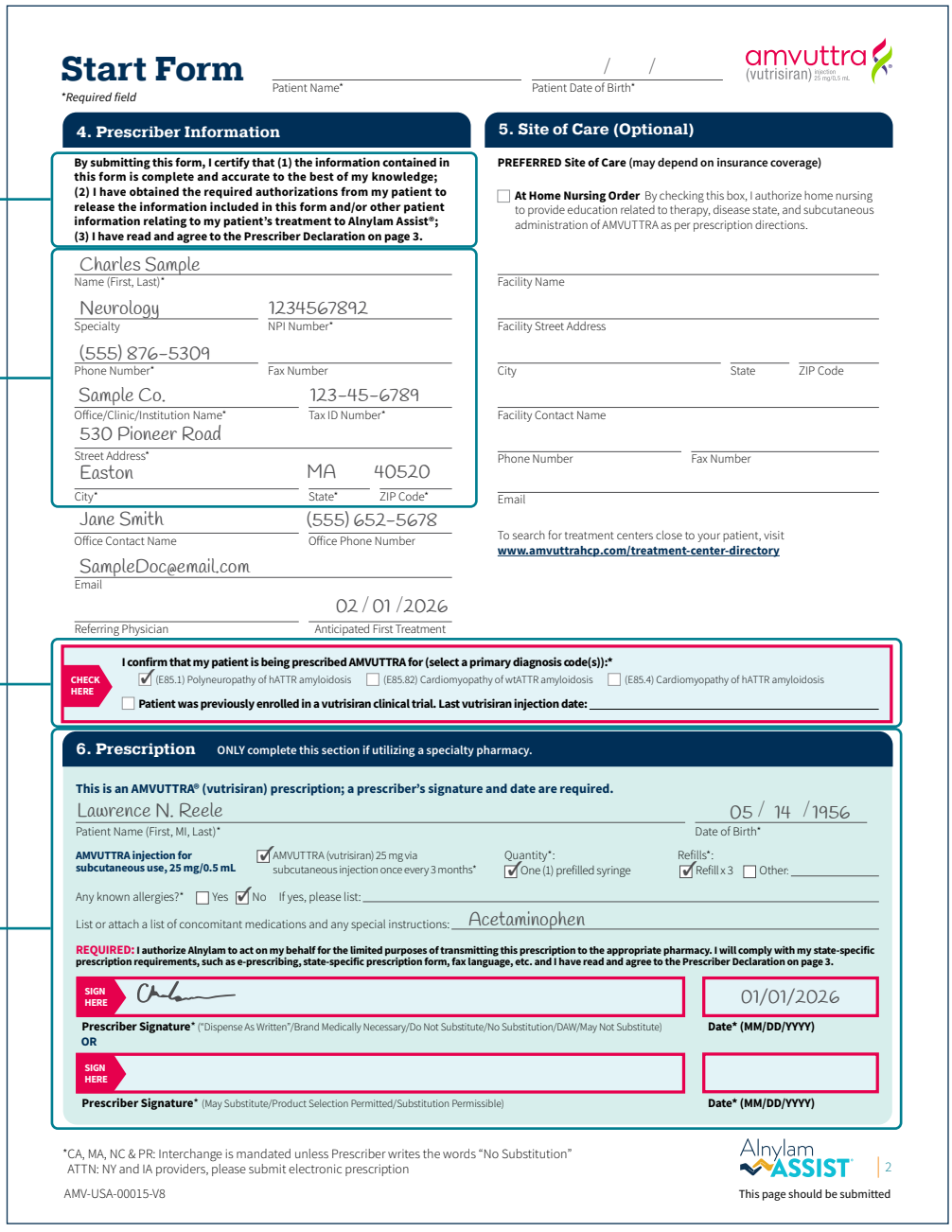
Primary Diagnosis Code(s)

Select the appropriate primary diagnosis code(s) for your patient. If your patient was previously enrolled in a vutrisiran clinical trial, check the box and enter the last injection date.

AMVUTTRA® (vutrisiran) Prescription and Signature

If prescribing via a specialty pharmacy, ensure the prescription fields, including the Patient Name and Date of Birth, are completed.

The prescriber's signature (or authorized substitution) and date are required once on Page 2.



Start Form

*Required field

Patient Name* ____ Patient Date of Birth* ____ / ____ / ____

amvuttra (vutrisiran)

4. Prescriber Information

By submitting this form, 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®; (3) I have read and agree to the Prescriber Declaration on page 3.

Charles Sample — Name (First, Last)*

Neurology — Specialty; 1234567892 — NPI Number*

(555) 876-5309 — Phone Number*; Fax Number

Sample Co. — Office/Clinic/Institution Name*; 123-45-6789 — Tax ID Number*

530 Pioneer Road — Street Address*

Easton — City*; MA — State*; 40520 — ZIP Code*

Jane Smith — Office Contact Name; (555) 652-5678 — Office Phone Number

SampleDoc@email.com — Email

Referring Physician; 02 / 01 /2026 — Anticipated First Treatment

5. Site of Care (Optional)

PREFERRED Site of Care (may depend on insurance coverage)

☐ **At Home Nursing Order** By checking this box, I authorize home nursing to provide education related to therapy, disease state, and subcutaneous administration of AMVUTTRA as per prescription directions.

Facility Name

Facility Street Address

City; State; ZIP Code

Facility Contact Name

Phone Number; Fax Number

Email

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

CHECK HERE

I confirm that my patient is being prescribed AMVUTTRA for (select a primary diagnosis code(s)):*

☑ (E85.1) Polyneuropathy of hATTR amyloidosis ☐ (E85.82) Cardiomyopathy of wtATTR amyloidosis ☐ (E85.4) Cardiomyopathy of hATTR amyloidosis

☐ **Patient was previously enrolled in a vutrisiran clinical trial. Last vutrisiran injection date:** ____

6. Prescription ONLY complete this section if utilizing a specialty pharmacy.

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

Lawrence N. Reele — Patient Name (First, MI, Last)*; 05 / 14 /1956 — Date of Birth*

AMVUTTRA injection for subcutaneous use, 25 mg/0.5 mL ☑ AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months* Quantity*: ☑ One (1) prefilled syringe Refills*: ☑ Refill x 3 ☐ Other: ____

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

List or attach a list of concomitant medications and any special instructions: Acetaminophen

REQUIRED: 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. and I have read and agree to the Prescriber Declaration on page 3.

SIGN HERE — 01/01/2026

Prescriber Signature* ("Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute) **Date* (MM/DD/YYYY)**

OR

SIGN HERE

Prescriber Signature* (May Substitute/Product Selection Permitted/Substitution Permissible) **Date* (MM/DD/YYYY)**

*CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"
ATTN: NY and IA providers, please submit electronic prescription

AMV-USA-00015-V8

Alnylam ASSIST | 2

This page should be submitted

Once you and your patient have completed, signed, and dated the form, fax pages 1 and 2 to 1-833-256-2747

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

Start Form

Please **complete, sign, and date the form**, then fax pages 1 and 2 to **1-833-256-2747**.

amvuttra (vutrisiran) injection 25 mg/0.5 mL

*Required field

1. Select Product Support*

☐ **Full Product Support** — **Full range of product support across access, affordability, ongoing treatment, and education.**

OR If you would like to select from parts of the comprehensive support Alnylam Assist offers, select the associated support from the list below.

- ☐ **Access & Treatment Initiation Support** — Support with navigating insurance and initiating treatment, including benefits verification, treatment site coordination and information regarding coding and reimbursement.
- ☐ **Affordability & Financial Support** — Information on coverage and financial assistance resources, including co-pay support, delay coverage, and patient assistance programs based on eligibility.
- ☐ **Ongoing Treatment Support** — Reminders and check-ins to support patients staying on track with treatment, including treatment follow-ups and ongoing patient education.
- ☐ **Patient Education Support** — Disease state and product education, with access to ongoing community events, resources, and information from an Alnylam Patient Education Liaison.

2. Patient Information

Name (First, MI, Last)*

Date of Birth* (/ /) Sex: ☐ Male ☐ Female

Email

Mobile Phone Number* ☐ Prefer not to leave voicemail

Alternative Phone Number (if available) ☐ Prefer not to leave voicemail

Language Translation? ☐ No ☐ Yes — If yes, indicate language

Street Address*

City* State* ZIP Code*

Alternative Contact Name (optional)

Alternative Contact Phone Number (optional) ☐ Prefer not to leave voicemail

Alternative Contact Email (optional)

3. Insurance Information

☐ Uninsured

PRIMARY Insurance Provider

Policy Number | Insurance Phone Number

Policyholder Name (First, MI, Last) | Policyholder Date of Birth (/ /)

SECONDARY Insurance Provider

Policy Number | Insurance Phone Number

Policyholder Name (First, MI, Last) | Policyholder Date of Birth (/ /)

PHARMACY Insurance Provider

Policy Number | Insurance Phone Number

Policyholder Name (First, MI, Last) | Policyholder Date of Birth (/ /)

Attach a copy of both sides of your MEDICAL insurance and PHARMACY insurance cards.

Please read this form carefully and ask any questions that you may have before signing. Without a patient signature, we are unable to process this form.

REQUIRED: I have read and agreed to the Patient Authorizations on page 3.

SIGN HERE

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

☐ **By checking this box, I agree to receive informational messages from Alnylam periodically at the phone number I provided. Message and data rates may apply. Message frequency varies. Text HELP for help and STOP to cancel. Terms & Conditions. Privacy Policy and Consumer Health Data Privacy Policy.**

Start Form

*Required field

Patient Name* _____ Patient Date of Birth* ___/___/___

amvuttra (vutrisiran) injection 25 mg/0.5 mL

4. Prescriber Information

By submitting this form, 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®; (3) I have read and agree to the Prescriber Declaration on page 3.

Name (First, Last)* _____

Specialty _____ NPI Number* _____

Phone Number* _____ Fax Number _____

Office/Clinic/Institution Name* _____ Tax ID Number* _____

Street Address* _____

City* _____ State* _____ ZIP Code* _____

Office Contact Name _____ Office Phone Number _____

Email _____

Referring Physician _____ Anticipated First Treatment ___/___/___

5. Site of Care (Optional)

PREFERRED Site of Care (may depend on insurance coverage)

☐ **At Home Nursing Order** By checking this box, I authorize home nursing to provide education related to therapy, disease state, and subcutaneous administration of AMVUTTRA as per prescription directions.

Facility Name _____

Facility Street Address _____

City _____ State _____ ZIP Code _____

Facility Contact Name _____

Phone Number _____ Fax Number _____

Email _____

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

CHECK HERE

I confirm that my patient is being prescribed AMVUTTRA for (select a primary diagnosis code(s)):*

☐ (E85.1) Polyneuropathy of hATTR amyloidosis ☐ (E85.82) Cardiomyopathy of wtATTR amyloidosis ☐ (E85.4) Cardiomyopathy of hATTR amyloidosis

☐ **Patient was previously enrolled in a vutrisiran clinical trial. Last vutrisiran injection date:** _____

6. Prescription

ONLY complete this section if utilizing a specialty pharmacy.

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

Patient Name (First, MI, Last)* _____ Date of Birth* ___/___/___

AMVUTTRA injection for subcutaneous use, 25 mg/0.5 mL

☐ AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months*

Quantity*: ☐ One (1) prefilled syringe

Refills*: ☐ Refill x 3 ☐ Other: _____

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

List or attach a list of concomitant medications and any special instructions: _____

REQUIRED: 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. and I have read and agree to the Prescriber Declaration on page 3.

SIGN HERE _____ Date* (MM/DD/YYYY) _____

Prescriber Signature* ("Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute)

OR

SIGN HERE _____ Date* (MM/DD/YYYY) _____

Prescriber Signature* (May Substitute/Product Selection Permitted/Substitution Permissible)

*CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"
ATTN: NY and IA providers, please submit electronic prescription

Patient Authorizations

amvuttra (vutrisiran) injection 25 mg/0.5 mL

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 additional information and support ("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®. 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 our Privacy Notice and Consumer Health Data Privacy Notice at www.alnylampolicies.com/privacy.

Authorization for Alnylam Assist® and Communications

I confirm I would like to enroll in the Alnylam Assist® program and authorize Alnylam, its affiliates, representatives, agents, and contractors 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 Patient Support, administering the Alnylam Assist® program, sharing educational and promotional materials related to my condition and/or therapy, or as otherwise required by Alnylam to meet its legal obligations. I understand that I may be contacted by Alnylam for market research purposes, including panels and surveys. For example, Alnylam may communicate with me periodically (such as by mail, phone, email, and/or text message, whether or not made with an auto-dialer or prerecorded voice) or my caregiver, use My Information to tailor the Alnylam Assist®–related communications and educational materials to my needs, and share information with My Providers about dispensing Alnylam medicine to me. Message and data rates may apply. 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. I understand my authorization in this form will relate to information and support with respect to any Alnylam medicine I have been prescribed or may be prescribed in the future.

Prescriber Declaration

By signing on page 2, 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 the completed Start Form is received by Alnylam Assist®

If you selected Full Product Support, Access & Treatment Initiation Support, Affordability & Financial Support or Ongoing Treatment Support for your patient

An Alnylam Case Manager will reach out to your patient. Please let them know.

For Access and Treatment Initiation Support an Alnylam Field Reimbursement Manager (FRM) will be reaching out to your office to educate on navigating insurance and initiating treatment, including benefits verification, treatment site coordination, and information about coding and reimbursement.



Prepare your patient
Let your patient know they will be receiving outreach from 1-833-256-2748 within 2 days

If you selected Patient Education Support for your patient

Your patient's Alnylam Patient Education Liaison (PEL) will reach out to them for disease state and AMVUTTRA education throughout their treatment journey.



Prepare your patient
Let your patient know they will be receiving outreach from their PEL



Once you and your patient have completed, signed, and dated the form, fax pages 1 and 2 to **1-833-256-2747**

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

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amvuttra® (vutrisiran) injection 25 mg/0.5 mL