

Alnylam ASSIST[®]

OXLUMO[®] (lumasiran) Start Form

After the decision to prescribe OXLUMO 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
to **1-833-256-2747**

How to complete the OXLUMO® (lumasiran) Start Form

PATIENT INFORMATION

After Completion

Fax the completed Start Form to 1-833-256-2747.

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 OXLUMO.


Patient Authorization and Signature

The signature of the patient or authorized patient representative, with the date, is required once in Section 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.

Insurance Information

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

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



*Required field

PATIENT INFORMATION

Lawrence N. Reelee Sex: Male Female

Prescriber Name (First, MI, Last)*

05/14/1956 LNReelee@email.com

Date of Birth (MM/DD/YYYY)* Email

(555) 137-1634 (555) 137-2745

Mobile Phone Number* Prefer not to leave voicemail 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 MA 15123

City State ZIP Code

Diana Reelee

Alternative Contact (First, Last) (optional)


Wife (555) 136-1522

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

Alternative Contact Email (optional)

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

REQUIRED: I have read and agree to the Patient Authorization and Support Program Authorization on page 3.

SIGN HERE


01/01/2025
Date* (MM/DD/YYYY)

Lawrence N. Reelee
Printed Name (First, Last)/Relationship to Patient (if applicable)

Patient/Legal Representative Signature* Date* Printed Name

Check if you do not have insurance **Attach a copy of both sides of your MEDICAL insurance and PRESCRIPTION insurance cards.**

ABC Insurance Co. 123456789101

PRIMARY Insurance Provider Policy Number

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

Policyholder Date of Birth (MM/DD/YYYY) (555) 136-2222

SECONDARY Insurance Provider Policy 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


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

Policyholder Date of Birth (MM/DD/YYYY) Insurance Phone Number

Please ensure your patient signs and dates in the red box above. Without a patient signature, we are unable to process this form.

G01-USA-00180-V5

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YOU CAN ALSO COMPLETE THE OXLUMO START FORM ONLINE AT:
www.alnylamassist.com/hcp/oxlumo/webform

How to complete the OXLUMO® (lumasiran) Start Form

HEALTHCARE PROVIDER INFORMATION

Priority Fields

Please ensure Prescriber 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.

OXLUMO® (lumasiran) Prescription

- Ensure you fill in the prescription fields, including the Patient Name and Date of Birth
- Ensure you fill in the Starting Dose and the Ongoing Dose and the patient's actual body weight (kg)

Diagnosis Code

Check the box to confirm your patient is being prescribed OXLUMO for the treatment of PH1.


Prescriber Authorization and Signature

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*: _____



3. Prescriber Information

PRESCRIBER INFORMATION

Charles Sample _____ Sample Co. _____
Prescriber Name (First, Last)* Office/Clinic/Institution Name*

Neurology _____ (555) 876-5309 _____
Specialty Phone Number*

(555) 867-5409 _____ 123-45-6789 _____
Fax Number Tax ID Number*

530 Pioneer Road _____ Easton MA 40520
Street Address* City* State* ZIP Code*

Jane Smith _____ SampleDoc@email.com _____
Office Contact Name Email

(555) 652-5678 _____ Paul Mitchell _____ February 1, 2025
Office Phone Number Referring Physician Anticipated First Treatment Date

4. Prescription

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

Lawrence N. Reece _____ 05/14/1956 _____
Patient Name (First, MI, Last)* Date of Birth (MM/DD/YYYY)*

OXLUMO Injection for subcutaneous use, 94.5 mg/0.5 mL

Treatment	Patient Weight (in kg)	Date Patient Weight Taken	Body Weight	OXLUMO Prescription	Total Calculated Dose	Number of Vials/Treatment	Refills
Starting Dose (given at 1-month intervals)			<input checked="" type="checkbox"/> Less than 10 kg	<input checked="" type="checkbox"/> 6 mg/kg once monthly for 3 doses	(mg) _____	94.5 mg/0.5 mL vial(s)	<input checked="" type="checkbox"/> Refill x 2
			<input type="checkbox"/> 10 kg to less than 20 kg	<input type="checkbox"/> 6 mg/kg once monthly for 3 doses	(mL) _____	<input type="checkbox"/> Other _____	
Ongoing Dose (begin 1 month after the last starting dose)			<input type="checkbox"/> Less than 10 kg	<input type="checkbox"/> 3 mg/kg once monthly	(mg) _____	94.5 mg/0.5 mL vial(s)	<input type="checkbox"/> Refill x 8
			<input type="checkbox"/> 10 kg to less than 20 kg	<input type="checkbox"/> 6 mg/kg once every 3 months (quarterly)	(mL) _____	<input checked="" type="checkbox"/> Refill x 2	
			<input checked="" type="checkbox"/> 20 kg and above	<input type="checkbox"/> 3 mg/kg once every 3 months (quarterly)		<input type="checkbox"/> Other _____	

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

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

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 OXLUMO as per prescription directions.

Facility _____
 Contact Name _____ Phone Number _____ Fax Number _____
 Facility Street Address _____ Email _____
 City _____ State _____ ZIP Code _____

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

CHECK HERE I confirm that my patient is being prescribed OXLUMO for the treatment of: E72.530 Primary hyperoxaluria, type 1

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. 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 _____

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

SIGN HERE _____

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


01/01/2025

Date* (MM/DD/YYYY)

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

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*Required field

1. Patient Information

PATIENT INFORMATION

Name (First, MI, Last)* _____ Sex: Male Female

Date of Birth (MM/DD/YYYY)* _____ 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 (First, Last) (optional) _____

Alternative Contact Relationship to Patient (optional) _____ Alternative Contact Phone Number (optional) Prefer not to leave voicemail _____

Alternative Contact Email (optional) _____

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

REQUIRED: I have read and agree to the Patient Authorization and Support Program Authorization on page 3.

SIGN
HERE

Patient/Legal Representative Signature*

Date* (MM/DD/YYYY)

Printed Name (First, Last)/Relationship to Patient (if applicable)

2. Insurance Information

Check if you do not have insurance **Attach a copy of both sides of your MEDICAL insurance and PRESCRIPTION insurance cards.**

PRIMARY Insurance Provider _____ Policy Number _____

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

Policyholder Date of Birth (MM/DD/YYYY) _____ Insurance Phone Number _____

SECONDARY Insurance Provider _____ Policy 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 _____

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

Policyholder Date of Birth (MM/DD/YYYY) _____ Insurance Phone Number _____

Please ensure your patient signs and dates in the red box above. Without a patient signature, we are unable to process this form.

*Required field

3. Prescriber Information

PRESCRIBER INFORMATION

Prescriber Name (First, Last)* _____ Office/Clinic/Institution Name* _____

Specialty _____ Phone Number* _____

Fax Number _____ Tax ID Number* _____ NPI Number* _____

Street Address* _____ City* _____ State* _____ ZIP Code* _____

Office Contact Name _____ Email _____

Office Phone Number _____ Referring Physician _____ Anticipated First Treatment Date _____

4. Prescription

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

Patient Name (First, MI, Last)* _____ Date of Birth (MM/DD/YYYY)* _____

OXLUMO Injection for subcutaneous use, 94.5 mg/0.5 mL

Treatment	Patient Weight (in kg)	Date Patient Weight Taken	Body Weight	OXLUMO Prescription	Total Calculated Dose	Number of Vials/Treatment	Refills
Starting Dose (given at 1-month intervals)			<input type="checkbox"/> Less than 10 kg <input type="checkbox"/> 10 kg to less than 20 kg <input type="checkbox"/> 20 kg and above	<input type="checkbox"/> 6 mg/kg once monthly for 3 doses <input type="checkbox"/> 6 mg/kg once monthly for 3 doses <input type="checkbox"/> 3 mg/kg once monthly for 3 doses	(mg) _____ (mL) _____	94.5 mg/0.5 mL vial(s)	<input type="checkbox"/> Refill x 2 <input type="checkbox"/> Other _____
Ongoing Dose (begin 1 month after the last starting dose)			<input type="checkbox"/> Less than 10 kg <input type="checkbox"/> 10 kg to less than 20 kg <input type="checkbox"/> 20 kg and above	<input type="checkbox"/> 3 mg/kg once monthly <input type="checkbox"/> 6 mg/kg once every 3 months (quarterly) <input type="checkbox"/> 3 mg/kg once every 3 months (quarterly)	(mg) _____ (mL) _____	94.5 mg/0.5 mL vial(s)	<input type="checkbox"/> Refill x 8 <input type="checkbox"/> Refill x 2 <input type="checkbox"/> Other _____

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

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

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 OXLUMO as per prescription directions.

Facility _____

Contact Name _____ Phone Number _____ Fax Number _____

Facility Street Address _____ Email _____

City _____ State _____ ZIP Code _____

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

CHECK HERE

I confirm that my patient is being prescribed OXLUMO for the treatment of: E72.530 Primary hyperoxaluria, type 1

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. 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

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

SIGN HERE

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

Date* (MM/DD/YYYY)

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

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.*

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.

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.

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 OXLUMO® (lumasiran) or any other Alnylam product, and any decision to prescribe OXLUMO 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,
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

Once the completed Start Form is received by Anylam Assist®



^aIf no site of care has been identified, Anylam Assist® can do a search for sites of care near the patient's preferred geographic location and confirm their in-/out-of-network status.

^bIf a reauthorization is required, a new request must be submitted.

^cAnylam Assist® can provide education on prior authorization requirements and processes, but cannot guarantee that a patient's prior authorization will be approved.

^dIf your patient has a new prescribing physician, a new Start Form is required and the process must be repeated.

