

# Alnylam Assist<sup>®</sup> Quick Start Program

The Alnylam Assist<sup>®</sup> Quick Start Program is available to new AMVUTTRA<sup>®</sup> (vutrisiran) patients who have either (1) been denied coverage through Prior Authorization (PA), Pre-Determination (Pre-D), Pre-Certification (Pre-Cert), or similar insurance documentation, or (2) have a PA, Pre-D, Pre-Cert, or similar insurance documentation still pending approval with the payer on the fourteenth (14th) calendar day from submission.

Prior to completing this form, ensure you have submitted a Start Form to Alnylam Assist<sup>®</sup> and you have submitted a PA or similar documentation to the payer. Then, you must complete, sign, and submit this form to request enrollment in the Alnylam Assist<sup>®</sup> Quick Start Program for your patient. If qualified, they will receive one dose of AMVUTTRA at no cost. The form must be signed by a licensed provider. **Please fax the completed and signed form to 1-833-256-2747.**

## STEP 1



Ensure the **Start Form and PA** or similar documentation has been submitted

## STEP 2





Fill out and sign the **Quick Start Enrollment Form** for your patient

## STEP 3



Fax the **completed and signed** form to **1-833-256-2747**



8AM–6PM, Monday–Friday  1-833-256-2748 |  1-833-256-2747  
To learn more, visit [www.alnylamassist.com/hcp](http://www.alnylamassist.com/hcp)

### Terms and Conditions:

One dose of AMVUTTRA will be shipped upon determination of the patient's eligibility. By signing and submitting this shipment request form, I state the following:

- I represent that the information contained in this form is complete and accurate and agree to notify Alnylam Assist<sup>®</sup> of any changes which could affect the eligibility of this patient or if any of the following statements are no longer true.
- I certify that the AMVUTTRA requested on this form and furnished free of charge by Alnylam will only be administered to the eligible patient listed above. Any units not used to treat this patient are considered wastage and will be properly discarded.
- I certify that there is a valid medical need for this patient's prescription for and treatment with AMVUTTRA.
- I certify that the patient is presently not on therapy and is experiencing a delay in payer authorization.
- I certify that the PA, Pre-D, Pre-Cert, or similar insurance documentation has been denied or has been submitted and pending approval for at least 14 calendar days.
- I certify that the PA, Pre-D, Pre-Cert, or similar insurance documentation has not yet been secured and/or the Letter of Agreement is pending.
- I am affiliated with the entity and location identified above.
- I will be responsible in all respects for the receipt and accountability of the pharmaceutical product shipped according to this request to the location specified above.
- I certify that I am the Provider or I am authorized to act for the Provider or institution for which I am signing.

# Alnylam Assist® Quick Start Program



Please fax the completed and signed form to 1-833-256-2747.

\*Required field

PROVIDER INFORMATION	
Provider Name*	MD State License #*
Facility Name	Facility License #*
Contact Name*	
Contact Phone Number	Contact Email

SITE OF CARE INFORMATION		
Address		
City	State	ZIP Code
Fax Number	Contact Name	
Contact Phone Number	Contact Email	
<input type="checkbox"/> <b>At Home Nursing Order</b> 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.		

PATIENT INFORMATION		
Patient Name (First, MI, Last)*	Date of Birth (MM/DD/YYYY)*	ZIP Code
Mobile Phone Number* <input type="checkbox"/> Prefer not to leave voicemail	Email	
Date of Scheduled Administration		

PRESCRIPTION INFORMATION	
<b>This is an AMVUTTRA® (vutrisiran) Prescription; a prescriber's signature and date are required.</b>	
Patient Name (First, MI, Last)*	Date of Birth (MM/DD/YYYY)*
<b>AMVUTTRA injection for subcutaneous use, 25 mg/0.5 mL</b> <input type="checkbox"/> AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months*      Quantity*: <input type="checkbox"/> One (1) prefilled syringe	
Any known allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please list: _____	
List or attach a list of concomitant medications and any special instructions: _____	

**SIGN HERE** [Signature Line]

[Date Line]

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

**Date\* (MM/DD/YYYY)**

**SIGN HERE** [Signature Line]

[Date Line]

**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

**Date\* (MM/DD/YYYY)**

