Start Form

onpattro® (patisiran) lipid complex injection 10 mg/5 mL

▷ 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

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

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative
Relationship to Patient	Date

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.
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.

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative
Relationship to Patient	Date

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.

Alnylam ASSIST®

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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:
Infusion Center Location Name & Address (if different from above):					Anticipated First Infusion Date:
Infusion Center Contact Name:			Phone:		Email:

Product Acquisition:

- ☐ Specialty Pharmacy:
  - ☐ Accredo Health Group Inc. ☐ CVS Specialty ☐ Orsini ☐ PANTHERx ☐ No preference
- ☐ Specialty Distributor (McKesson Specialty or McKesson Plasma and Biologics)
- ☐ Unknown

7. ONPATTRO® (patisiran) Dosing Information

Patient Name (First, MI, Last):		Patient Date of Birth: Month/Day/Year:
Primary Diagnosis Code:		
Dose: (Recommended dose is 0.3 mg/kg supplied as 10 mg/5 mL vials) ONPATTRO (patisiran) _____ mg IV every 3 weeks	Number of Vials:	Patient Weight (kg):

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 ONPATTRO or any other Alnylam product, and any decision to prescribe ONPATTRO 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
- ▷ Alnylam may convey on my behalf the information described herein to be sent to a pharmacy, if applicable

☐ **I confirm that my patient is being prescribed ONPATTRO for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults**

X	
Prescriber signature (stamps not acceptable)	Date

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Indication

ONPATTRO® (patisiran) is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

Important Safety Information

Infusion-Related Reactions

Infusion-related reactions (IRRs) have been observed in patients treated with ONPATTRO. In a controlled clinical study, 19% of ONPATTRO-treated patients experienced IRRs, compared to 9% of placebo-treated patients. The most common symptoms of IRRs with ONPATTRO were flushing, back pain, nausea, abdominal pain, dyspnea, and headache.

To reduce the risk of IRRs, patients should receive premedication with a corticosteroid, acetaminophen, and antihistamines (H1 and H2 blockers) at least 60 minutes prior to ONPATTRO infusion. Monitor patients during the infusion for signs and symptoms of IRRs. If an IRR occurs, consider slowing or interrupting the infusion and instituting medical management as clinically indicated. If the infusion is interrupted, consider resuming at a slower infusion rate only if symptoms have resolved. In the case of a serious or life-threatening IRR, the infusion should be discontinued and not resumed.

Reduced Serum Vitamin A Levels and Recommended Supplementation

ONPATTRO 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 ONPATTRO. Higher doses than the RDA should not be given to try to achieve normal serum vitamin A levels during treatment with ONPATTRO, as serum 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 ONPATTRO were upper respiratory tract infections (29%) and infusion-related reactions (19%).

For additional information about ONPATTRO, 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