OXLUMO® (lumasiran) for injection 94.5 mg/0.5 mL

Start Form

Alnylam ASSIST®

▷ 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 – 4**

For Patients

Alnylam Assist® Enrollment

(Sections 1 – 4 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; (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: Month/Day/Year		Email:	
Street Address:			
City:		State:	ZIP:
Home Phone #: ☐ **Preferred** ☐ **Okay to leave message**	Mobile Phone #: ☐ **Preferred** ☐ **Okay to leave message**	Alternative Phone # (if available): ☐ **Preferred** ☐ **Okay to leave message**	
Caregiver Name (optional):	Caregiver Relationship to Patient (optional):	Caregiver Phone (optional): ☐ **Okay to leave message**	
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 INSURANCE and PRESCRIPTION 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

Please see Important Safety Information on page 4, and full Prescribing Information.

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 a 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

Please see Important Safety Information on page 4, and full Prescribing Information.

OXLUMO® (lumasiran) for injection 94.5 mg/0.5 mL

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Alnylam ASSIST

For Healthcare Providers

(Sections 5 – 7 to be read and completed by **Healthcare Provider**)

5. Prescriber Information

Name (First, Last):			Office/Clinic/Institution Name:	Specialty:
Practice Street Address:			City: State:	ZIP:
Phone:	Fax:	Tax ID #:	National Provider ID (NPI) #:	State License #:
Office Contact Name:			Phone:	Email:

Referring Physician:

Product Acquisition:

☐ Specialty Pharmacy: ○ Orsini ○ PANTHERx ○ No preference ☐ Unknown

☐ Specialty Distributor (McKesson Specialty or McKesson Plasma and Biologics)

Anticipated First Treatment Date:

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

Full Patient Name (First, Last and Middle Initial):

Patient Date of Birth: Month/Day/Year:

Primary Diagnosis Code:

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

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

List or attach a list of concomitant medications:

Special Instructions:

☐ If acquiring through Orsini or PANTHERx, please check here to authorize ancillary supplies, such as needles and syringes, as needed to administer treatment.

☐ **I confirm that my patient is being prescribed OXLUMO for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary and plasma oxalate levels in children and adults.**

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.

X _____ _____

Prescriber Signature (No Stamps) Dispense as Written Date

X _____ _____

Prescriber Signature (No Stamps) Substitution Permitted Date

Desired Site of Care

☐ Home Injection (see patient home address) ☐ Physician Office (see provider office address)

☐ Alternate Medical Facility (provide facility name and address) ☐ Facility to Home (first dose at facility; remainder at home)

Facility Name/Address _____

▷ Continue to page 4 to complete the prescriber portion of the Start Form

Please see Important Safety Information on page 4, and full Prescribing Information.

7. 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 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 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®

x	
Prescriber signature (stamps not acceptable)	Date

INDICATION

OXLUMO® (lumasiran) is indicated for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary and plasma oxalate levels in children and adults.

IMPORTANT SAFETY INFORMATION

Adverse Reactions

The most common (≥20%) adverse reaction reported in patients treated with OXLUMO was injection site reaction. Injection site reactions included erythema, swelling, pain, hematoma, pruritus, and discoloration.

Pregnancy and Lactation

No data are available on the use of OXLUMO in pregnant women. No data are available on the presence of OXLUMO in human milk or its effects on breastfed infants or milk production. Consider the developmental and health benefits of breastfeeding along with the mother's clinical need for OXLUMO and any potential adverse effects on the breastfed child from OXLUMO or the underlying maternal condition.

For additional information about OXLUMO, please see 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