Alnylam ASSIST®

GIVLAARI® (givosiran) Start Form

After the decision to prescribe GIVLAARI 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**

GIVLAARI® (givosiran) injection for subcutaneous use 189 mg/mL

How to complete the GIVLAARI® (givosiran) Start Form

PATIENT INFORMATION

After Completion

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

Mobile Phone Number and Voicemail

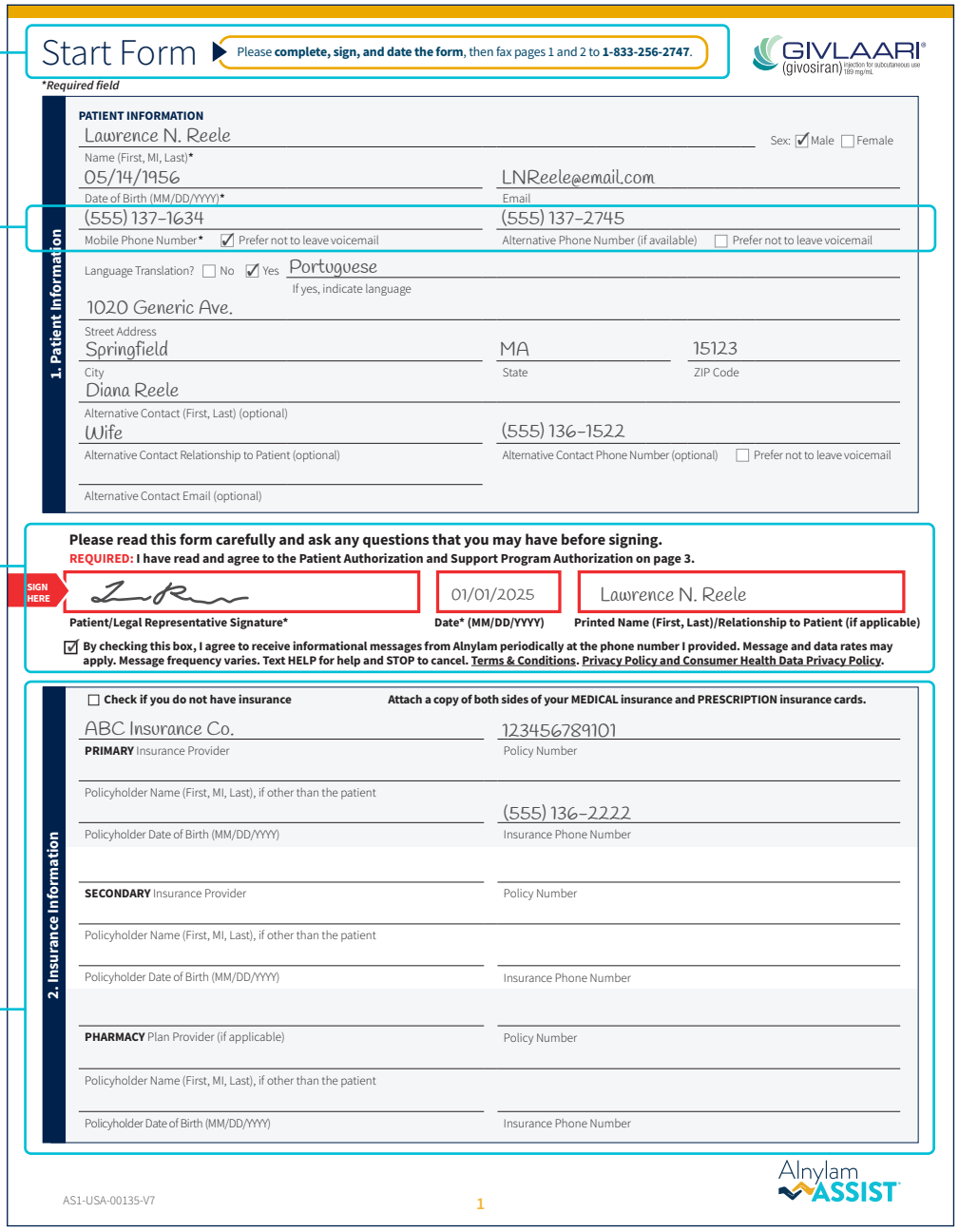
By checking "Prefer not to leave voicemail", you are declining voicemail messages from Alnylam Assist®. Declining voicemails from Alnylam Assist® may result in delays in starting treatment with GIVLAARI.

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**.

GIVLAARI® (givosiran) Injection for subcutaneous use 189 mg/mL

*Required field

1. Patient Information

PATIENT INFORMATION

Lawrence N. Reele — Sex: ☑ Male ☐ Female
Name (First, MI, Last)*

05/14/1956 — LNReele@email.com
Date of Birth (MM/DD/YYYY)* — Email

(555) 137-1634 — ☑ Prefer not to leave voicemail — (555) 137-2745 — ☐ Prefer not to leave voicemail
Mobile Phone Number* — Alternative Phone Number (if available)

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

1020 Generic Ave.
Street Address

Springfield — MA — 15123
City — State — ZIP Code

Diana Reele
Alternative Contact (First, Last) (optional)

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

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 — [signature] — 01/01/2025 — Lawrence N. Reele

Patient/Legal Representative Signature* — **Date* (MM/DD/YYYY)** — **Printed Name (First, Last)/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.**

2. Insurance Information

☐ **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
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

Alnylam ASSIST

AS1-USA-00135-V7 — 1

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

How to complete the GIVLAARI® (givosiran) Start Form

HEALTHCARE PROVIDER INFORMATION

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.

GIVLAARI® (givosiran) Prescription

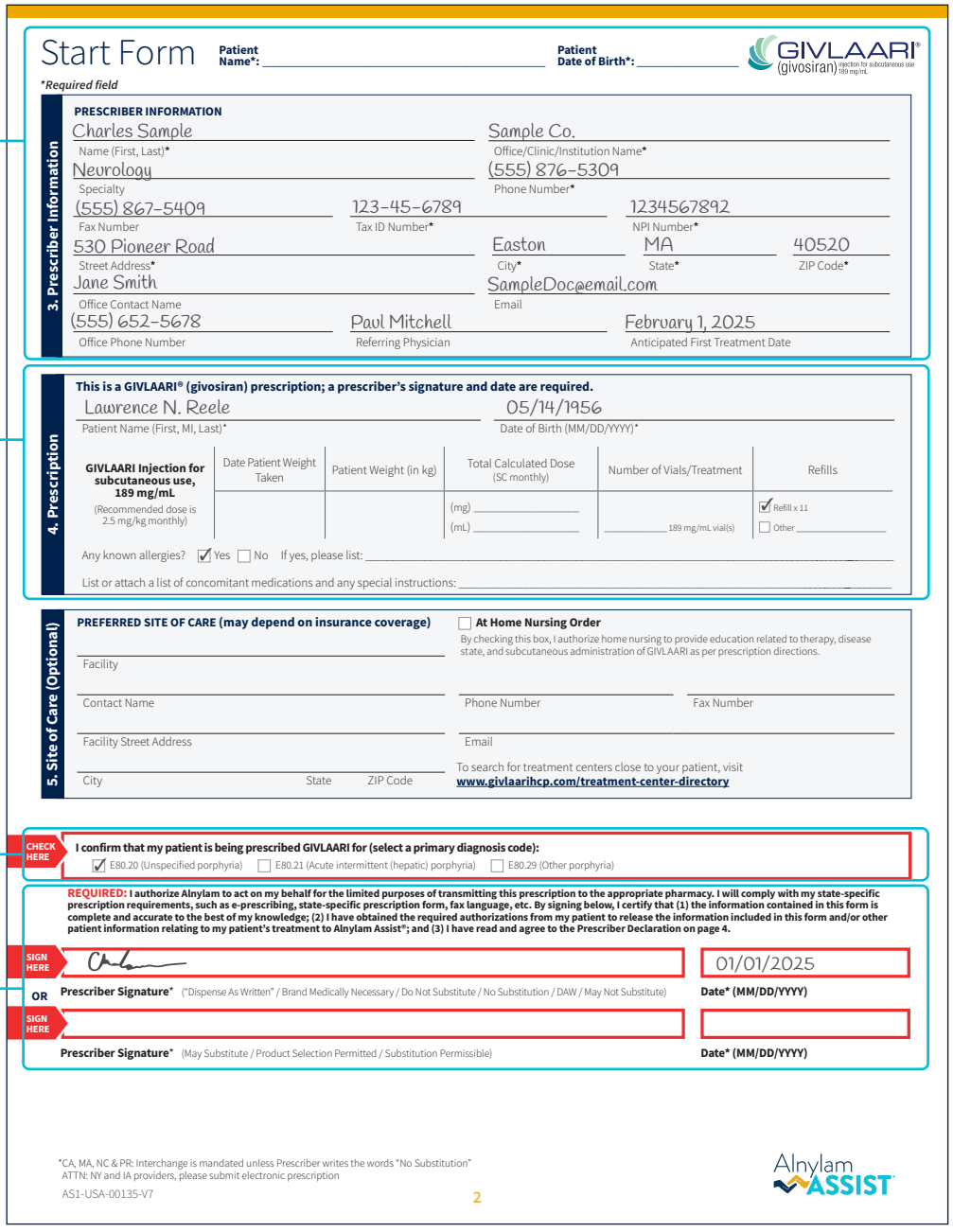
Ensure you fill in the prescription fields, including the Patient Name and Date of Birth.

Primary Diagnosis Codes

Select the appropriate primary diagnosis code(s) for your patient.

Prescriber Authorization and Signature

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



Start Form

Patient Name*: _____ Patient Date of Birth*: _____ GIVLAARI® (givosiran) injection for subcutaneous use 189 mg/mL

*Required field

3. Prescriber Information

PRESCRIBER INFORMATION

Charles Sample — Name (First, Last)*
Sample Co. — Office/Clinic/Institution Name*
Neurology — Specialty
(555) 876-5309 — Phone Number*
(555) 867-5409 — Fax Number
123-45-6789 — Tax ID Number*
1234567892 — NPI Number*
530 Pioneer Road — Street Address*
Easton — City*
MA — State*
40520 — ZIP Code*
Jane Smith — Office Contact Name
SampleDoc@email.com — Email
(555) 652-5678 — Office Phone Number
Paul Mitchell — Referring Physician
February 1, 2025 — Anticipated First Treatment Date

4. Prescription

This is a GIVLAARI® (givosiran) prescription; a prescriber's signature and date are required.

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

GIVLAARI Injection for subcutaneous use, 189 mg/mL (Recommended dose is 2.5 mg/kg monthly)	Date Patient Weight Taken	Patient Weight (in kg)	Total Calculated Dose (SC monthly)	Number of Vials/Treatment	Refills
			(mg) _____ (mL) _____	_____ 189 mg/mL vial(s)	☑ Refill x 11 ☐ 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)

Facility
Contact Name
Facility Street Address
City State ZIP Code

☐ At Home Nursing Order

By checking this box, I authorize home nursing to provide education related to therapy, disease state, and subcutaneous administration of GIVLAARI as per prescription directions.

Phone Number
Fax Number
Email

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

CHECK HERE

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

☑ E80.20 (Unspecified porphyria) ☐ E80.21 (Acute intermittent (hepatic) porphyria) ☐ E80.29 (Other porphyria)

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 — 01/01/2025

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

AS1-USA-00135-V7

2

Alnylam ASSIST

Start Form

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

GIVLAARI® (givosiran) injection for subcutaneous use 189 mg/mL

**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)**

☐ **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.**

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

Alnylam ASSIST®

Start Form

Patient Name*: _____ **Patient Date of Birth*:** _____

GIVLAARI® (givosiran) injection for subcutaneous use 189 mg/mL

**Required field*

3. Prescriber Information

PRESCRIBER INFORMATION

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 a GIVLAARI® (givosiran) prescription; a prescriber's signature and date are required.

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

	Date Patient Weight Taken	Patient Weight (in kg)	Total Calculated Dose (SC monthly)	Number of Vials/Treatment	Refills
GIVLAARI Injection for subcutaneous use, 189 mg/mL (Recommended dose is 2.5 mg/kg monthly)			(mg) _____ (mL) _____	_____ 189 mg/mL vial(s)	☐ Refill x 11 ☐ 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)

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.givlaarihcp.com/treatment-center-directory**

☐ **At Home Nursing Order**

By checking this box, I authorize home nursing to provide education related to therapy, disease state, and subcutaneous administration of GIVLAARI as per prescription directions.

CHECK HERE

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

☐ E80.20 (Unspecified porphyria) ☐ E80.21 (Acute intermittent (hepatic) porphyria) ☐ E80.29 (Other porphyria)

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 _____ **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

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.

Start Form

GIVLAARI® (givosiran) injection for subcutaneous use 189 mg/mL

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 GIVLAARI® (givosiran) or any other Alnylam product, and any decision to prescribe GIVLAARI 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 Alnylam Assist®

1. Alnylam Case Manager does initial benefit investigation[a]
If a patient's insurance or site of care changes, a new benefit investigation must be done

BENEFIT INVESTIGATION

2. Alnylam Case Manager relays results of benefit investigation to you and your patient during "Benefits Counseling Call"
This includes information about prior authorization (if required)

IF REQUIRED

Prescribing physician submits prior authorization or works with identified specialty pharmacy to submit on their behalf
- It is the responsibility of the prescribing physician to submit the required documentation
- If the prior authorization is not approved, a resubmission or appeal may be required by the prescriber

Prior authorization is approved[b,c]

3. Alnylam Case Manager supports in the assessment of financial assistance options, eligibility, and site of care preferences

4. Patient is "order ready"

TREATMENT[d]

5. Once patient is approved to start treatment, the product order is placed at the designated site of care

Patient receives GIVLAARI® (givosiran) and schedules next treatment

[a]If no site of care has been identified, Alnylam Assist® can do a search for sites of care near the patient's preferred geographic location and confirm their in-/out-of-network status.
[b]If a reauthorization is required, a new request must be submitted.
[c]Alnylam Assist® can provide education on prior authorization requirements and processes, but cannot guarantee that a patient's prior authorization will be approved.
[d]If your patient has a new prescribing physician, a new Start Form is required and the process must be repeated.

Alnylam® PHARMACEUTICALS

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