amvuttra (vutrisiran) injection 25 mg/0.5 mL

Alnylam Assist® Quick Start Program

The Alnylam Assist® Quick Start Program is available to new AMVUTTRA® (vutrisiran) patients experiencing a delay in coverage for a minimum of fourteen (14) calendar days. A delay may be caused by Prior Authorization (PA), Pre-Determination (Pre-D), Pre-Certification (Pre-Cert), or similar insurance documentation not being approved. This form must be completed, signed, and submitted to request enrollment in the Alnylam Assist® Quick Start Program for your patient. If qualified, they will receive one dose of the product 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

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

STEP 2

Be sure the form has the **required provider signature**

STEP 3

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

Alnylam ASSIST®

8AM–6PM, Monday–Friday : 1-833-256-2748 | : 1-833-256-2747
To learn more, visit 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® 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 Prior Authorization (PA), Pre-Determination (Pre-D), Pre-Certification (Pre-Cert), or similar insurance documentation has been submitted and pending for at least 14 business days.
- I certify that the Prior Authorization (PA), Pre-Determination (Pre-D), Pre-Certification (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

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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

☐ **At Home Nursing Order**

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* ☐ Prefer not to leave voicemail

Email

Date of Scheduled Administration

PRESCRIPTION INFORMATION

This is an AMVUTTRA® (vutrisiran) Prescription; a prescriber's signature and date are required.

Patient Name (First, MI, Last)*

Date of Birth (MM/DD/YYYY)*

AMVUTTRA injection for subcutaneous use, 25 mg/0.5 mL ☐ AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months* Quantity*: ☐ One (1) prefilled syringe

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

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

SIGN HERE

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

Alnylam® PHARMACEUTICALS