Alnylam ASSIST®

AMVUTTRA® (vutrisiran) Start Form

After the decision to prescribe AMVUTTRA 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**

amvuttra® (vutrisiran) injection 25 mg/0.5 mL

How to complete the AMVUTTRA® (vutrisiran) Start Form

PATIENT INFORMATION

After Completion

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

Mobile Phone Number and Voicemail

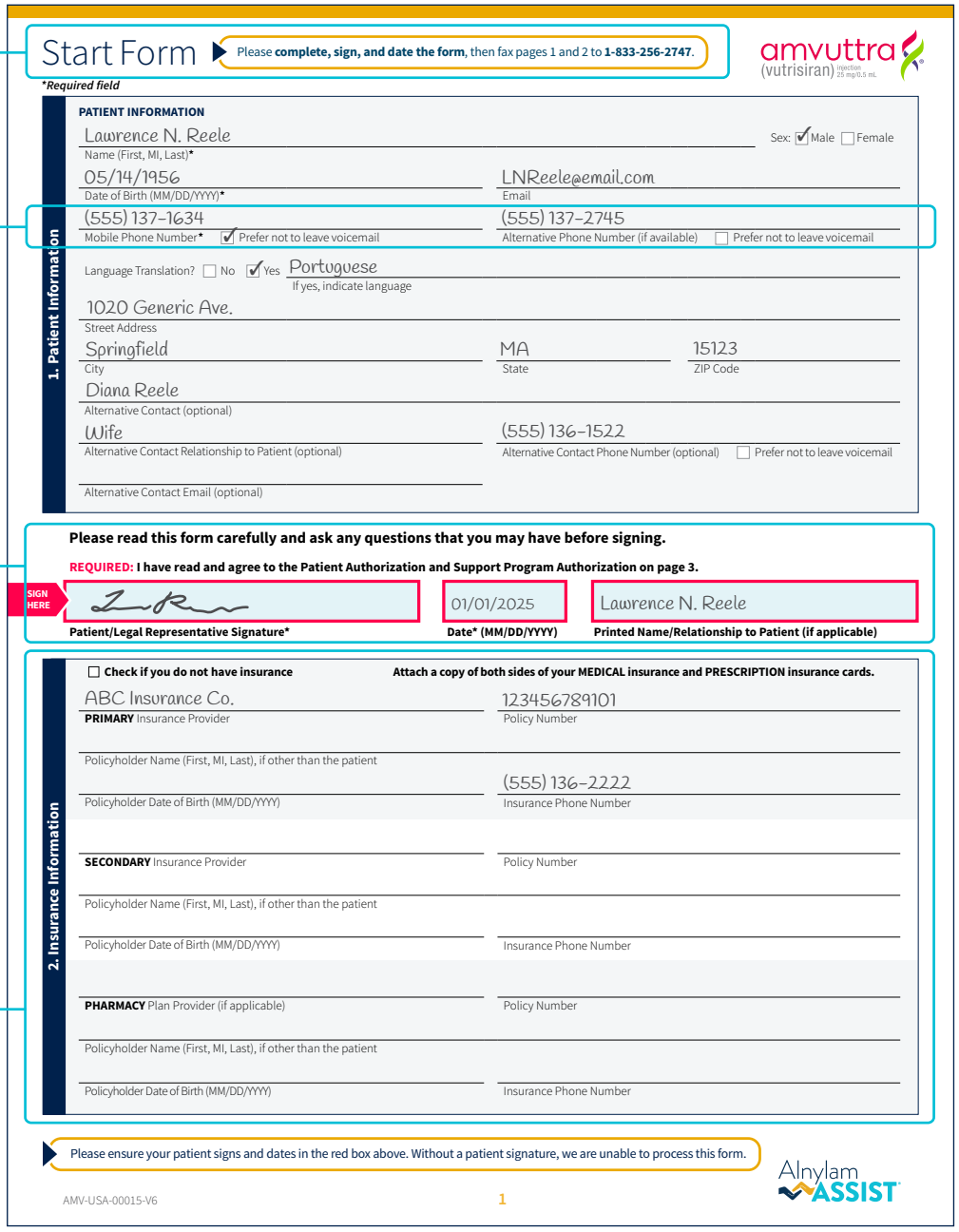
By checking "Prefer not to leave voicemail", you are declining voicemail messages from Alnylam Assist®. Declining voicemails from Alnylam Assist® may result in delays in starting treatment with AMVUTTRA.

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**.

amvuttra (vutrisiran) injection 25 mg/0.5 mL

*Required field

1. Patient Information

PATIENT INFORMATION

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

05/14/1956 — Date of Birth (MM/DD/YYYY)*

LNReele@email.com — Email

(555) 137-1634 — Mobile Phone Number* ☑ Prefer not to leave voicemail

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

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

1020 Generic Ave. — Street Address

Springfield — City

MA — State

15123 — ZIP Code

Diana Reele — Alternative Contact (optional)

Wife — Alternative Contact Relationship to Patient (optional)

(555) 136-1522 — 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*

01/01/2025 — Date* (MM/DD/YYYY)

Lawrence N. Reele — Printed Name/Relationship to Patient (if applicable)

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. — **PRIMARY** Insurance Provider

123456789101 — 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

Please ensure your patient signs and dates in the red box above. Without a patient signature, we are unable to process this form.

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Alnylam ASSIST

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

How to complete the AMVUTTRA® (vutrisiran) 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.

AMVUTTRA® (vutrisiran) Prescription

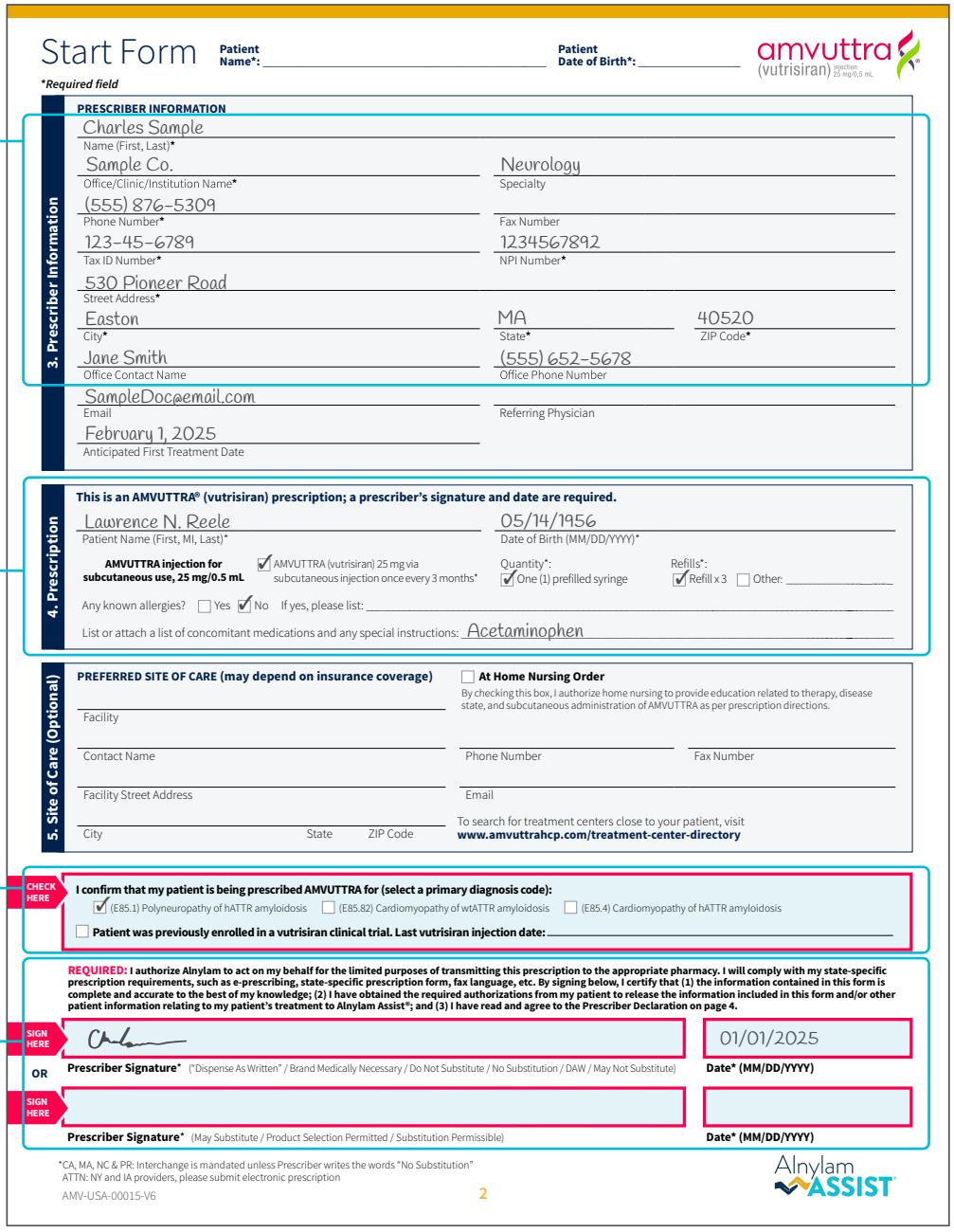
Ensure you fill in the prescription fields, including the Patient Name and Date of Birth.

Primary Diagnosis Codes

Select the appropriate primary diagnosis code(s) for your patient. If your patient was previously enrolled in a vutrisiran clinical trial, check the box and enter the last injection date.

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*: _____

amvuttra (vutrisiran) injection 25 mg/0.5 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*

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

(555) 652-5678
Office Phone Number

SampleDoc@email.com
Email

Referring Physician

February 1, 2025
Anticipated First Treatment Date

4. Prescription

This is an AMVUTTRA® (vutrisiran) 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)*

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

Refills*: ☑ Refill x 3 ☐ Other: _____

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

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

5. Site of Care (Optional)

PREFERRED SITE OF CARE (may depend on insurance coverage)

☐ **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.

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

CHECK HERE

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

☑ (E85.1) Polyneuropathy of hATTR amyloidosis ☐ (E85.82) Cardiomyopathy of wtATTR amyloidosis ☐ (E85.4) Cardiomyopathy of hATTR amyloidosis

☐ **Patient was previously enrolled in a vutrisiran clinical trial. Last vutrisiran injection date:** _____

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

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2

Alnylam ASSIST

Start Form

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

amvuttra (vutrisiran) injection 25 mg/0.5 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 (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/Relationship to Patient (if applicable)**

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

Please ensure your patient signs and dates in the red box above. Without a patient signature, we are unable to process this form.

Alnylam ASSIST

Start Form

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

amvuttra (vutrisiran) injection 25 mg/0.5 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 | Office Phone Number

Email | Referring Physician

Anticipated First Treatment Date

4. Prescription

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

Refills*: ☐ Refill x 3 ☐ 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

☐ **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.

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

CHECK HERE

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

☐ (E85.1) Polyneuropathy of hATTR amyloidosis ☐ (E85.82) Cardiomyopathy of wtATTR amyloidosis ☐ (E85.4) Cardiomyopathy of hATTR amyloidosis

☐ **Patient was previously enrolled in a vutrisiran clinical trial. Last vutrisiran injection date:** _____

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

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

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 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 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 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 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.

Alnylam Assist® Enrollment
(Sections 1 and 2 to be completed and signed 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.

Start Form

amvuttra (vutrisiran) injection 25 mg/0.5 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 AMVUTTRA® (vutrisiran) or any other Alnylam product, and any decision to prescribe AMVUTTRA 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 AMVUTTRA® (vutrisiran) 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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amvuttra® (vutrisiran) injection 25 mg/0.5 mL