Alnylam ASSIST®

How to Complete the AMVUTTRA® (vutrisiran) Start Form

amvuttra® (vutrisiran) injection 25 mg/0.5 mL

How to complete the AMVUTTRA® (vutrisiran) Start Form

This brochure will show you how to complete the Start Form. The notes on each page provide details to help ensure the form is filled out correctly. The Start Form serves as your patient's enrollment in Alnylam Assist® and requires the signature of both you and your patient, unless the patient is currently prescribed an Alnylam medicine and is enrolled in Alnylam Assist®.

It is important to note the following before submitting the Start Form:

- Ensure highlighted key areas are correctly filled out
- Confirm that you and your patient sign where indicated
- Make sure the site of care information is provided for patients not receiving home administration, if known

Options for getting started

1. Complete and submit the **electronic Start Form** with your patient

OR

2. Complete the **paper Start Form** with your patient and fax to 1-833-256-2747

OR

3. Begin the Start Form, filling in all details required from a healthcare professional, and then have your patient complete the form via **DocuSign**

All 3 options to get started can be found at **www.AlnylamAssist.com/hcp**.

Alnylam ASSIST®

For patients

After Completion

Fax pages 1 and 3 of the completed Start Form to Alnylam Assist® at 1-833-256-2747

Preferred Phone Number and Voicemail Checkbox

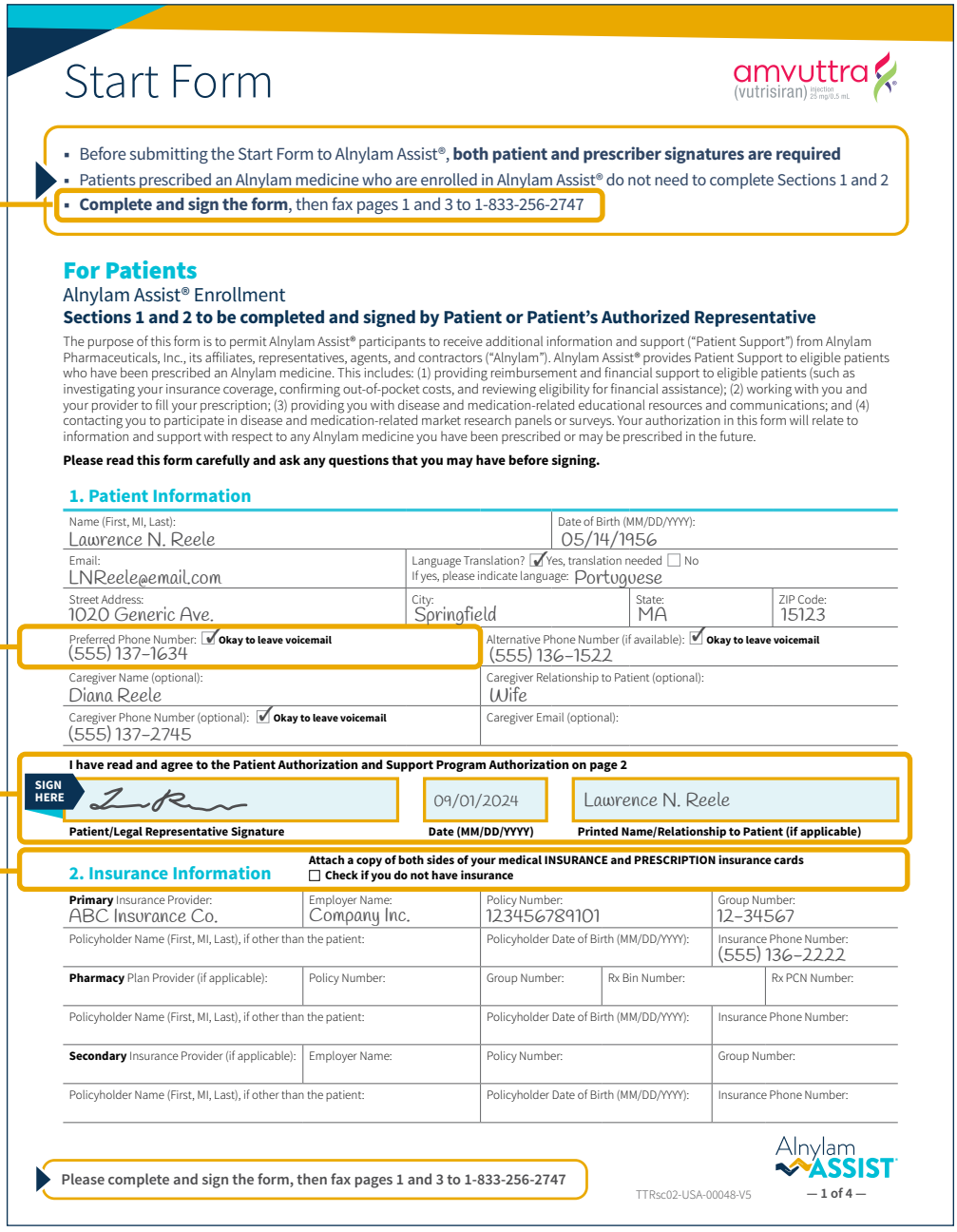
By allowing Alnylam Assist® to leave voicemails, delays in benefit verification and other communications can be avoided.

Signature of Patient

The signature of the patient or authorized patient representative, with the date, is required **once** on this page in Section 1 unless the patient is currently prescribed an Alnylam medicine and is already enrolled in Alnylam Assist®.

Insurance Information

Patients (or their authorized representatives) can fill in the provided fields or attach copies of both sides of their insurance and pharmacy benefits cards.



Start Form

amvuttra (vutrisiran) injection 25 mg/0.5 mL

- Before submitting the Start Form to Alnylam Assist®, **both patient and prescriber signatures are required**
- Patients prescribed an Alnylam medicine who are enrolled in Alnylam Assist® do not need to complete Sections 1 and 2
- **Complete and sign the form**, then fax pages 1 and 3 to 1-833-256-2747

For Patients

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.

Please read this form carefully and ask any questions that you may have before signing.

1. Patient Information

Name (First, MI, Last): Lawrence N. Reele			Date of Birth (MM/DD/YYYY): 05/14/1956
Email: LNReele@email.com	Language Translation? ☑ Yes, translation needed ☐ No If yes, please indicate language: Portuguese		
Street Address: 1020 Generic Ave.	City: Springfield	State: MA	ZIP Code: 15123
Preferred Phone Number: ☑ **Okay to leave voicemail** (555) 137-1634		Alternative Phone Number (if available): ☑ **Okay to leave voicemail** (555) 136-1522	
Caregiver Name (optional): Diana Reele		Caregiver Relationship to Patient (optional): Wife	
Caregiver Phone Number (optional): ☑ **Okay to leave voicemail** (555) 137-2745		Caregiver Email (optional):	

I have read and agree to the Patient Authorization and Support Program Authorization on page 2

SIGN HERE [signature] | 09/01/2024 | Lawrence N. Reele

Patient/Legal Representative Signature | **Date (MM/DD/YYYY)** | **Printed Name/Relationship to Patient (if applicable)**

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: ABC Insurance Co.	Employer Name: Company Inc.	Policy Number: 123456789101		Group Number: 12-34567
Policyholder Name (First, MI, Last), if other than the patient:		Policyholder Date of Birth (MM/DD/YYYY):		Insurance Phone Number: (555) 136-2222
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 (MM/DD/YYYY):		Insurance Phone Number:
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 (MM/DD/YYYY):		Insurance Phone Number:

Please complete and sign the form, then fax pages 1 and 3 to 1-833-256-2747

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Authorization to share protected health information/ authorization for Alnylam Assist® enrollment

Start Form

amvuttra (vutrisiran) injection 25 mg/0.5 mL

3. 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.*

4. 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.

Please complete and sign the form, then fax pages 1 and 3 to 1-833-256-2747

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Alnylam ASSIST

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Authorization to Share Protected Health Information

Confirm the patient has read and agreed to the Authorization to Share Protected Health Information by signing **once** on page 1 in Section 1.

Authorization for Alnylam Assist® and Communications

Confirm the patient has read and agreed to the Authorization for Alnylam Assist® and Communications by signing **once** on page 1 in Section 1.

Alnylam ASSIST®

For healthcare providers

AMVUTTRA® (vutrisiran) Prescription

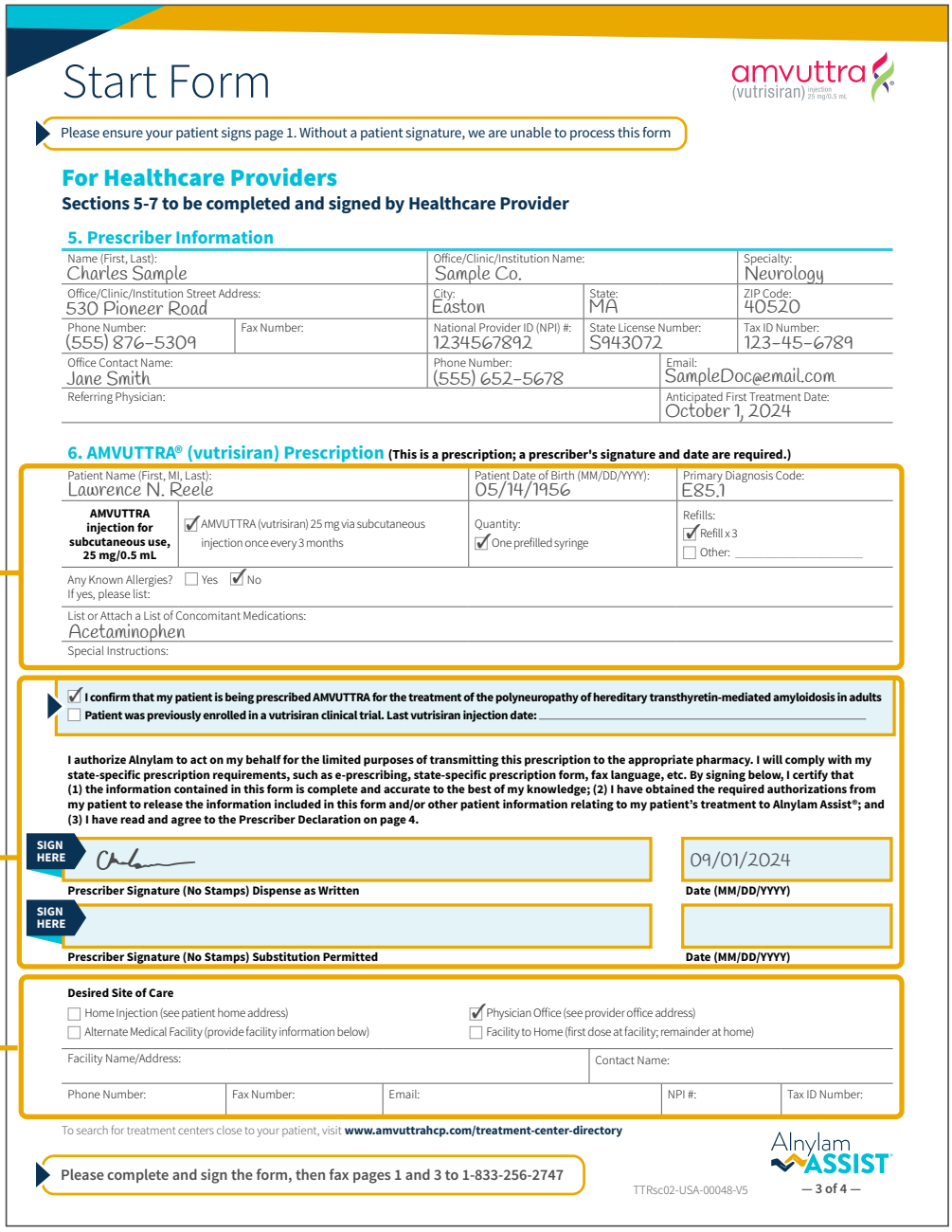
- Ensure you fill in the prescription fields
- Make sure to include the primary diagnosis code

Signature of Prescriber

- Confirm that your patient is being prescribed AMVUTTRA as indicated by checking the box
- Check the second box if your patient was previously enrolled in a vutrisiran clinical trial
- The prescriber's signature (or authorized substitution) and date are required **once** on this page

Desired Site of Care

Ensure that your patient's desired site of care has been provided. Please note that home administration may also be an option.[a]



Start Form

amvuttra (vutrisiran) Injection 25 mg/0.5 mL

Please ensure your patient signs page 1. Without a patient signature, we are unable to process this form

For Healthcare Providers

Sections 5-7 to be completed and signed by Healthcare Provider

5. Prescriber Information

Name (First, Last): Charles Sample		Office/Clinic/Institution Name: Sample Co.		Specialty: Neurology
Office/Clinic/Institution Street Address: 530 Pioneer Road		City: Easton	State: MA	ZIP Code: 40520
Phone Number: (555) 876-5309	Fax Number:	National Provider ID (NPI) #: 1234567892	State License Number: S943072	Tax ID Number: 123-45-6789
Office Contact Name: Jane Smith		Phone Number: (555) 652-5678		Email: SampleDoc@email.com
Referring Physician:				Anticipated First Treatment Date: October 1, 2024

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

Patient Name (First, MI, Last): Lawrence N. Reele		Patient Date of Birth (MM/DD/YYYY): 05/14/1956	Primary Diagnosis Code: E85.1
AMVUTTRA injection for subcutaneous use, 25 mg/0.5 mL	☑ AMVUTTRA (vutrisiran) 25 mg via subcutaneous injection once every 3 months	Quantity: ☑ One prefilled syringe	Refills: ☑ Refill x 3 ☐ Other: _____

Any Known Allergies? ☐ Yes ☑ No
If yes, please list:

List or Attach a List of Concomitant Medications: Acetaminophen

Special Instructions:

☑ **I confirm that my patient is being prescribed AMVUTTRA for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults**
☐ **Patient was previously enrolled in a vutrisiran clinical trial. Last vutrisiran injection date:** _____

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 _____ 09/01/2024
Prescriber Signature (No Stamps) Dispense as Written **Date (MM/DD/YYYY)**

SIGN HERE _____
Prescriber Signature (No Stamps) Substitution Permitted **Date (MM/DD/YYYY)**

Desired Site of Care

☐ Home Injection (see patient home address) ☑ Physician Office (see provider office address)
☐ Alternate Medical Facility (provide facility information below) ☐ Facility to Home (first dose at facility; remainder at home)

Facility Name/Address:			Contact Name:	
Phone Number:	Fax Number:	Email:	NPI #:	Tax ID Number:

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

Please complete and sign the form, then fax pages 1 and 3 to 1-833-256-2747

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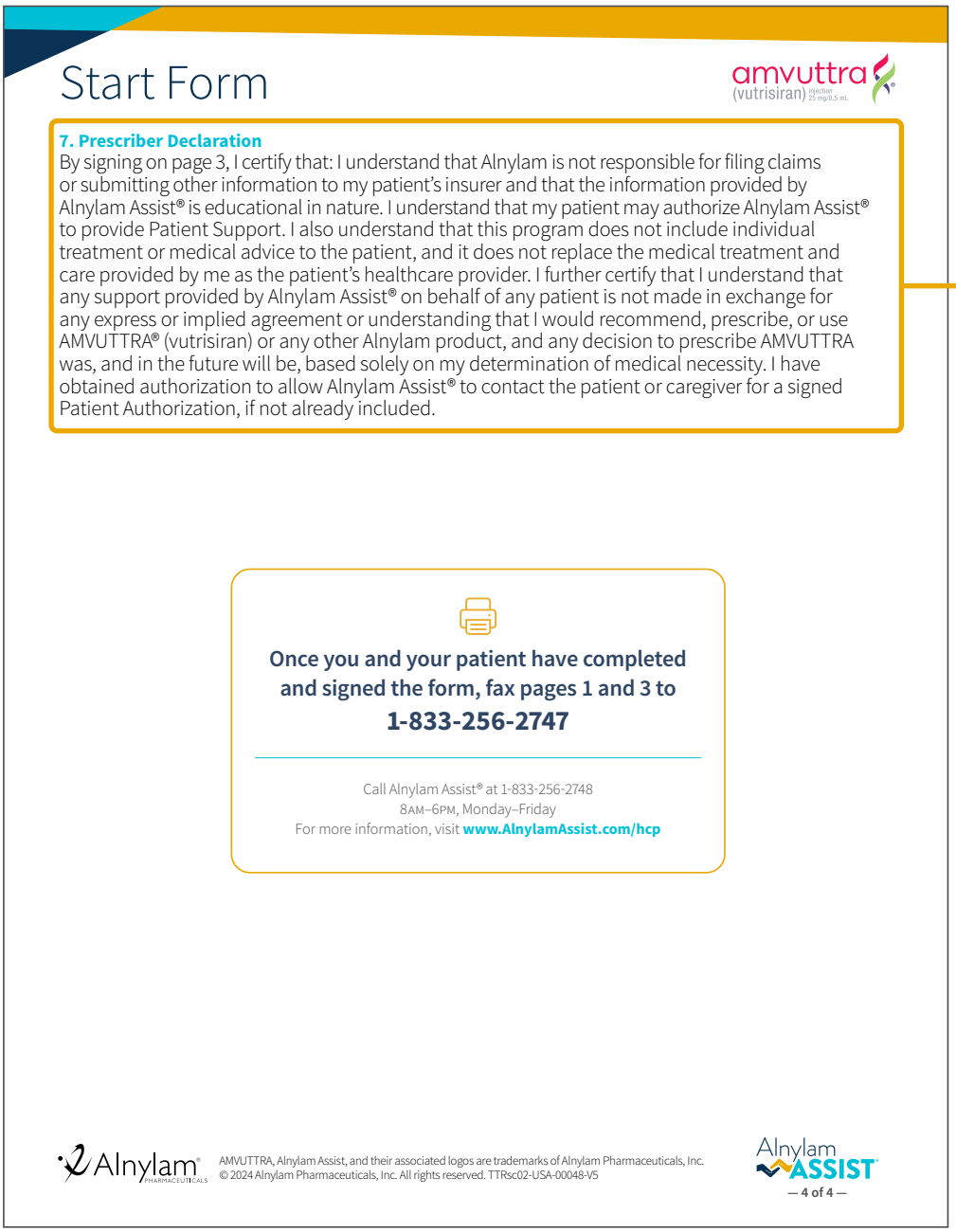
[a]Home administration may be an option for some patients. The decision for a patient to receive home administration should be made after evaluation and recommendation by the treating physician and may not be covered by all insurance plans.

Alnylam ASSIST®

Prescriber declaration



Start Form

amvuttra (vutrisiran) injection 25 mg/0.5 mL

7. Prescriber Declaration
By signing on page 3, 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 and signed the form, fax pages 1 and 3 to
1-833-256-2747

Call Alnylam Assist® at 1-833-256-2748
8AM–6PM, Monday–Friday
For more information, visit **www.AlnylamAssist.com/hcp**

Alnylam ASSIST
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Prescriber Declaration
Confirm you have read and agreed to the Prescriber Declaration by signing on page 3 in Section 6.

Alnylam ASSIST

Alnylam ASSIST®

8 AM–6 PM, Monday–Friday

: 1-833-256-2748 | : 1-833-256-2747

To learn more,
visit www.AlnylamAssist.com/hcp.

Alnylam ASSIST®

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 Call Counsel"
This includes information about prior authorization (if required)

3. Alnylam Case Manager confirms copay affordability and site of care

4. Patient is "order ready"

TREATMENT[d]

5. Physician places order through specialty pharmacy or specialty distributor

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]

Patient receives AMVUTTRA® (vutrisiran) treatment and schedules next treatment

[a]If no site of care has been identified, the Alnylam Case Manager 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

amvuttra® (vutrisiran) injection 25 mg/0.5 mL