Onpattro Order
(Patisiran)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant the Diagnosis ☐ Medications List ☐ Recent Office Notes

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: Neuropathic Heredofamilial Amyloidosis

ICD-10: E85.1

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

PRE-MEDICATIONS:

(60 minutes prior)

Diphenhydramine:	50mg	IV	Acetaminophen:	500mg	PO
Ranitidine:	10mg	IV	Dexamethasone:	10mg	IV

ONPATTRO (PATISIRAN) IV DOSING

☐ < 100 kg, recommended dosage is 0.3 mg/kg once every 3 weeks

☐ ≥ 100 kg, recommended dosage is 0.3 mg once every 3 weeks

Next Dose Due: ___/___/___

Start Form

Alnylam ASSIST®

▷ Before submitting the Start Form to Alnylam Assist®, patient **and** prescriber signatures are required

For Patients

Alnylam Assist® Enrollment

(Sections 1 – 5 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 (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; and (3) providing you with disease and medication-related educational resources and communications.

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

1. Patient Information

Name (First, Middle, Last):			Gender: ☐ Male ☐ Female
Date of Birth: Month/Day/Year	Email:		
Street Address:			
City:	State:	Zip:	
Preferred Phone Number: ☐ **Okay to leave voicemail**	Alternative Phone Number: ☐ **Okay to leave voicemail**		
Caregiver Name (optional):	Caregiver Relationship to Patient (optional):	Caregiver Phone (optional):	
Language translation? ☐ Yes, translation needed ☐ No If yes, please indicate language:			

2. Insurance Information

Attach a copy of both sides of your insurance card ☐ Check if you do not have insurance

Primary Insurance Name:	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 Name (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 Name (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.

Start Form

Alnylam ASSIST®

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 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 or regulations. I understand that my pharmacy will receive payment from Alnylam for disclosing My Information to Alnylam. I understand that I may refuse to sign this Authorization, and that doing so will not affect my ability to receive treatment or benefits to which I am otherwise entitled. I further understand that my treatment, insurance enrollment, and eligibility for insurance benefits are not conditioned upon my 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, 300 Third Street, Cambridge, MA 02142 or by sending an email to privacy@alnylam.com. I understand that if I revoke this Authorization, Alnylam will stop using and sharing My Information, 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.

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 Alnylam Assist®. 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 my 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.

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative
Relationship to Patient	Date

5. Opt-in to Receive Marketing Communications (optional)

Alnylam would like to contact you regarding Alnylam's medicines or Alnylam information that may be of interest to you.

☐ By checking this box, I authorize Alnylam, and companies working with Alnylam, to contact me by mail, email, fax, and/or telephone regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. **I understand that I am not required to provide this consent as a condition of receiving any Alnylam medicine or services from Alnylam.**

Start Form

For Healthcare Providers

(Sections 6 – 8 to be read and completed by **Healthcare Provider**)

6. Prescriber Information

Name (First, Last):			Practice Name:		Specialty:
Practice Street Address:			City:		State:
Zip:	Phone:	Fax:	National Provider ID (NPI) Number:		State License Number:
Office Contact Name:			Phone:		Email:
Infusion Center Location Name & Address (if different from above):					Anticipated First Infusion Date:
Infusion Center Contact Name:			Phone:		Email:

Product Acquisition:

Specialty Pharmacy: ☐ Orsini Healthcare ☐ US Bioservices ☐ No preference

☐ Specialty Distributor (McKesson)

☐ Unknown

7. ONPATTRO® (patisiran) Dosing Information

☐ I confirm that my patient is being prescribed ONPATTRO for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults

Primary Diagnosis Code:

Dose: (Recommended dose is 0.3 mg/kg supplied as 10 mg/5 mL vials) ONPATTRO (patisiran) _____ mg IV every 3 weeks	Number of Vials:	Patient Weight (kg):

List concomitant medications:

I appoint Alnylam, its affiliates, and their representatives to convey on my behalf the information described herein to be sent to a pharmacy, if applicable.

X _____ _____

Prescriber signature (stamps not acceptable) | Date

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

Start Form

8. 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 advisory 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 service 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 ONPATTRO® or any other Alnylam product, and any decision to prescribe ONPATTRO 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

ONPATTRO® (patisiran) is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

Important Safety Information

Infusion-Related Reactions

Infusion-related reactions (IRRs) have been observed in patients treated with ONPATTRO. In a controlled clinical study, 19% of ONPATTRO-treated patients experienced IRRs, compared to 9% of placebo-treated patients. The most common symptoms of IRRs with ONPATTRO were flushing, back pain, nausea, abdominal pain, dyspnea, and headache.

To reduce the risk of IRRs, patients should receive premedication with a corticosteroid, acetaminophen, and antihistamines (H1 and H2 blockers) at least 60 minutes prior to ONPATTRO infusion. Monitor patients during the infusion for signs and symptoms of IRRs. If an IRR occurs, consider slowing or interrupting the infusion and instituting medical management as clinically indicated. If the infusion is interrupted, consider resuming at a slower infusion rate only if symptoms have resolved. In the case of a serious or life-threatening IRR, the infusion should be discontinued and not resumed.

Reduced Serum Vitamin A Levels and Recommended Supplementation

ONPATTRO treatment leads to a decrease in serum vitamin A levels. Supplementation at the recommended daily allowance (RDA) of vitamin A is advised for patients taking ONPATTRO. Higher doses than the RDA should not be given to try to achieve normal serum vitamin A levels during treatment with ONPATTRO, as serum levels do not reflect the total vitamin A in the body.

Patients should be referred to an ophthalmologist if they develop ocular symptoms suggestive of vitamin A deficiency (e.g. night blindness).

Adverse Reactions

The most common adverse reactions that occurred in patients treated with ONPATTRO were upper respiratory tract infections (29%) and infusion-related reactions (19%).

For additional information about ONPATTRO, please see the full Prescribing Information.