

Prescription Start Form



Phone: 1-866-AKCEATX (1-866-252-3289)

Fax: 1-866-AKCEAFX (1-866-252-3239)

Email: AkceaConnect@sobi.com

All fields mandatory

1. PATIENT INFORMATION

First Name	Middle Initial	Last Name	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Home Address			City	
State	ZIP Code	Last Four Digits of SS# XXX-XX- <input type="text"/>		
Shipping Address (If Not Home Address)				
Care of (If Different Than Pt.)	City		State	ZIP Code
Home Phone # <input type="checkbox"/> OK to Leave Message	Mobile # <input type="checkbox"/> OK to Text	Best Time to Call	Preferred Language (If Other Than English)	
Email Address		Pt. Representative/ Caregiver Name		
Relationship	Pt. Rep Phone # <input type="checkbox"/> OK to Leave Message	Pt. Rep Email Address		

2. INSURANCE INFORMATION: Please provide copies of front and back of all medical and prescription insurance cards If no insurance please check here ■

Primary Insurance	Policy Holder	Date of Birth (mm/dd/yyyy)		
Policy #	Group #	Phone #		
Secondary Insurance	Policy Holder	Date of Birth (mm/dd/yyyy)		
Policy #	Group #	Phone #		
Prescription Insurance	Policy Holder	Date of Birth (mm/dd/yyyy)		
Member ID #	Group #	Rx Bin #	PCN #	Phone #

3. HEALTHCARE PROVIDER (HCP) INFORMATION

HCP First Name	HCP Last Name	Office/Clinic/ Institution Name		
National Provider ID (NPI) #	Tax ID #	State License #	Phone #	
Address				
City		State	ZIP Code	
Office Contact		Contact Phone #	Office Fax #	
Office Contact Email Address			Preferred Method of Contact	

4. PRESCRIPTION INFORMATION: TEGSEDI® (inotersen) 284 MG/1.5 ML NDC# 72126-007-03 PREFILLED SYRINGE

Primary Diagnosis: Hereditary Transthyretin Amyloidosis (hATTR) ICD-10: E85.1 Other Diagnosis/Code _____

NKDA Allergies _____

Concurrent Medications _____

Nurse Injection Training: Authorize RN visit to provide education related to therapy, disease state, administration and dosing, and titration per prescriber order

Inject 284 mg/1.5 mL subcutaneously Once weekly Other _____ Quantity: _____
(Maximum 30 day supply)

IMPORTANT: TEGSEDI REMS Patient Attestation form required every 90 days to continue therapy. Refills _____

Prescriber Signature (Dispense as Written)

X _____ Date _____

Prescriber Signature (Substitution Allowed)

X _____ Date _____

Supervising Physician Signature (where required) **X** _____ Date _____

Prescriber signature required for consent and to validate prescriptions. Prescriber attests that this is his/her signature. NO STAMPS. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

AKCEA® CONNECT is committed to partnering with patients and HCPs to ensure safety and proper injection technique. Learning and using proper injection technique is crucial for patients taking TEGSEDI® (inotersen). AKCEA CONNECT will provide up to three sessions of injection training by a nurse and a sharps container for enrolled patients. Patients covered by government plans may not qualify for this program.

PATIENT INFORMATION

First Name _____	Last Name _____	Date of Birth (mm/dd/yyyy) _____
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5. LABORATORY TESTING AND MEDICAL HISTORY

TEGSEDI® should not be initiated in patients with a platelet count < 100 x 10⁹/L or UPCR ≥ 1000 mg/g.

Platelets ≥ 100 x 10 ⁹ /L <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Date drawn _____	UPCR < 1000 mg/g <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Date drawn _____
eGFR _____	Date drawn _____	Serum creatinine _____	Date drawn _____
ALT _____	Date drawn _____	AST _____	Date drawn _____
Total bilirubin _____	Date drawn _____	Urinalysis _____	Date drawn _____

<p>History of:</p> <p>Polyneuropathy <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: G63)</p> <p>Bil. Carpal Tunnel Syndrome <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: G56.03)</p> <p>Cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: I43)</p> <p>Syncope <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: R55)</p> <p>Cardiac Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: I49.9)</p> <p>Congestive Heart Failure <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: I50.9)</p> <p>Transplant History <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: Z94)</p> <p>Transplant Type: _____</p>	<p>Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: K59.1)</p> <p>Constipation <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: K59.00)</p> <p>Unexplained Weight Loss <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: R63.4)</p> <p>Renal Nephropathy <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (ICD-10: N29)</p> <p>Vitreous Opacities <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Autonomic Dysfunctions <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Ambulatory Status:</p> <p style="padding-left: 40px;">Unassisted <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/></p>
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6. CURRENT AND HISTORICAL MEDICATIONS

<p>Diflunisal <input type="checkbox"/> Current? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Duration of therapy _____</p> <p>Tafamidis <input type="checkbox"/> Current? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Duration of therapy _____</p> <p>Patisiran <input type="checkbox"/> Current? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Duration of therapy _____</p>	<p>Other <input type="checkbox"/> _____</p> <p>_____</p> <p>_____</p>
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7. CONSENT, AND STATEMENT OF MEDICAL NECESSITY: HCP SIGNATURE REQUIRED

I certify that TEGSEDI is medically necessary for this patient and that I have reviewed this therapy with the patient and will be monitoring the patient's treatment. I verify that the patient and the healthcare provider information on the prescription start form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

I authorize dispensing pharmacies, e.g., Accredo® and other designated operators of the AKCEA CONNECT Program, to perform a preliminary assessment of benefit verification for this patient and furnish information requested by the patient's insurer that is available on this form. I understand that insurance verification is ultimately the responsibility of the provider and third-party reimbursement is affected by a variety of factors. While Accredo tries to provide accurate information, they and Sobi make no representations or warranties as to the accuracy of the information provided.

I authorize AKCEA CONNECT Program, its affiliates, agents, and contractors (collectively, Sobi) to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

This Privacy Policy describes the information we collect about you on this form, how we protect the data, how we use it and your rights. We collect identifiers and characteristics of protected classification such as medical conditions in order to enroll patients in our REMS program, provide patients with a prescription, or enroll patients in our Patient Services Program. We only use the information on this form for the business purpose described on the form. We use technical, administrative and procedural measures in an attempt to safeguard personal data from unauthorized access or use. We only share this information internally or with service providers who support the business process. We never sell patient information. You may have rights to request access, deletion of your data. Please find further details in our full Privacy Policy, accessible at the following address: <https://sobi-northamerica.com/privacy-policy>.

CLINICIAN SIGNATURE: REQUIRED FOR DOCUMENTATION

I verify that the patient and the healthcare provider information on this prescription start form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I certify that my patient has agreed in writing to be contacted by AKCEA CONNECT Program or dispensing pharmacy, e.g., Accredo, and be furnished with Program or other information or materials.

Prescriber Authorization Signature _____	Date _____
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Please see full Prescribing Information for TEGSEDI, including boxed WARNING regarding the risk of Thrombocytopenia and Glomerulonephritis, in the pocket of the accompanying folder.