Redemplo® (plozasiran) Start Form

Rely On Redemplo™ Patient Support Program

Instructions:

- Complete the form, sign electronically with a digital signature, and submit directly online **OR** you can complete the form, print, sign, and fax to **1-844-673-3367**
- You can submit the Start Form without the patient's signature to start the prescription process
- If patient consent is missing, the patient can complete a Patient Consent form online or a Care Coordinator will contact the patient to obtain consent

1. Patient Information

*First Name: _____ Middle Initial: _____ *Last Name: _____

*Gender: ○ Male ○ Female *Date of Birth (MM/DD/YYYY): _____ *Primary Phone: ○ Mobile ○ Home _____

*Address: _____ Alternate Phone #: _____

*City: _____ *State: _____ *ZIP: _____ Email: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Permission to Leave Message: ○ Yes ○ No

Best Time to Contact: ☐ Morning (8 AM to 10 AM ET)

☐ Day (10 AM to 5 PM ET) ☐ Evening (after 5 PM ET)

Preferred Language:

○ English ○ Spanish ○ Other _____

Caregiver and/or Authorized Representative Information:

Name: _____ Relationship to Patient: _____

Phone: _____ Email: _____

2. Insurance Information

Please attach front and back copy of all insurance cards.

Primary Medical Insurance:

*Provider: _____ *Phone: _____

*Member Name: _____ *Member ID #: _____ *Group #: _____

*Member Date of Birth (MM/DD/YYYY): _____

Secondary Medical Insurance:

Provider: _____ Phone: _____

Member Name: _____ Member ID #: _____ Group #: _____

Member Date of Birth (MM/DD/YYYY): _____

Pharmacy Insurance:

*Pharmacy Benefit Name: _____ *Phone: _____ *Rx BIN #: _____

*Group #: _____ *Insurance ID #: _____ *Rx PCN #: _____

3. Healthcare Professional Information

*First Name: _____ *Last Name: _____

*Specialty: _____ *NPI #: _____ *Facility/Office Name: _____

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Office Contact Name: _____ *Office Contact Phone #: _____

*Office Contact Fax #: _____

*Office Contact Email: _____

Please see Important Safety Information on page 4 and full Prescribing Information for REDEMPLO.

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*First Name: _____ *Last Name: _____ *Date of Birth (MM/DD/YYYY): _____

4. Clinical Information

*Diagnosis: ○ FCS (Familial Chylomicronemia Syndrome) ○ Other: _____

ICD-10-CM Diagnosis Code: ○ E78.3 Hyperchylomicronemia ○ Other: _____

Diagnosis Date (MM/DD/YYYY): _____

Please indicate which tests have been conducted to confirm patient's diagnosis (please attach clinical documentation of these test results).

☐ Fasting triglyceride levels of ≥880 mg/dL

Level: _____ Date test completed (MM/DD/YYYY): _____

☐ Acute pancreatitis episodes

(not caused by alcohol or cholelithiasis)

5. Prescription Information

☐ Redemplo Prescription

Redemplo 25 mg/0.5 mL prefilled syringe

Directions: inject 0.5 mL (25 mg) subcutaneously every 3 months

Quantity: 1 prefilled syringe

Refill: ○ 3 Refills ○ Other: _____ Refills

Note: NY prescribers must send the prescription electronically. Electronic prescriptions should be sent to Vanscoy Pharmacy (NPI 1598522195).

☐ **Quick Start:** If eligible, patient may be able to receive a dose of Redemplo if they are experiencing a delay from their insurance provider for their prescription. Prior to Quick Start dose approval, all required information for prior authorization must be received. Please contact 1-844-REDEMPLO (1-844-733-3675) for full program details and eligibility. Arrowhead Pharmaceuticals reserves the right to rescind, revoke, or amend the program without notice.

6. Healthcare Professional Certification

By signing this form, I am indicating a prescribing decision has been made. In addition, I am certifying treatment with Redemplo indicated above is medically necessary for this patient, and I have received authorization to release the medical and/or other patient information relating to this therapy to the specialty pharmacy and its affiliates, agents, and representatives to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I certify that, to the best of my knowledge, the patient and physician information in this form is complete, accurate, and consistent with applicable privacy regulations.

Healthcare Professional Name (Print): _____

SIGN

Healthcare Professional Signature: _____ **Date (MM/DD/YYYY):** _____

(Physician attests this is his/her legal signature. NO STAMPS ALLOWED)

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7. Patient Consent

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

What is the purpose of this Authorization? To provide you with the services of the Rely On Redemplo Patient Support Program, Arrowhead Pharmaceuticals, Inc. (**Arrowhead**), the manufacturer of Redemplo and its agents, representatives and service providers (collectively, **Arrowhead Parties**), may need to review information about your health and medical condition (**Health Information**) that has been collected by your doctors, pharmacies, and other health care providers (collectively, **HCPs**). Before any HCP can disclose your Health Information to the Arrowhead Parties, they must obtain your permission to do so. If you decide to provide permission, you will need to sign this Authorization.

What types of Health Information will be disclosed? If you provide your permission, HCPs may disclose your medical records, records of prescription medications prescribed to you, information about your health care plan benefits, and financial records relating to your health care. This may also include demographic information.

To whom will my Health Information be disclosed and for what purposes? Your Health Information will be disclosed to the Arrowhead Parties, which include without limitation, reimbursement support service providers that assist Arrowhead in providing the Rely On Redemplo Patient Support Program, including to verify treatment and payment issues with your HCPs; investigate and assist with coordination of insurance coverage and payment for Arrowhead medicines; coordinate prescription fulfillment and financial assistance; coordinate the provision of patient educational support; for quality assurance purposes and to perform internal analysis to improve their services. When your Health Information is disclosed to the Arrowhead Parties, it may no longer be protected by certain federal or state health privacy laws.

Information about Authorization.

- This Authorization will be effective for one year
- You may revoke this Authorization at any time by calling Rely On Redemplo at 1-844-REDEMPLO (1-844-733-3675); you cannot do so by mail or email. Any such revocation will not apply to any information already used or disclosed based on this Authorization prior to Arrowhead's receipt of the revocation request

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*First Name: _____ *Last Name: _____ *Date of Birth (MM/DD/YYYY): _____

- You can decline to sign this Authorization and doing so will not affect your treatment or payment for treatment, insurance coverage, or eligibility for benefits. However, if you do not sign this Authorization, you will not be able to participate in the Rely On Redemplo Patient Support Program. You are entitled to a copy of the executed Authorization and can request additional copies by contacting Rely On Redemplo at 1-844-REDEMPLO (1-844-733-3675).

8. Patient Authorization

☐ **I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:**

Patient Name (print): _____

Patient Date of Birth: _____

Patient Address: _____

_____

Patient Phone: _____ Patient Email Address: _____

Name of Patient Representative and Authority to Act:

_____

☐ Court Appointed ☐ Power of Attorney for Healthcare Decisions

☐ Other: _____

SIGN

Signature of Patient or Patient Representative: _____

Date (MM/DD/YYYY): _____

INDICATION

REDEMPLO® (plozasiran) is indicated as an adjunct to diet to reduce triglycerides in adult patients with familial chylomicronemia syndrome (FCS).

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS: None.

ADVERSE REACTIONS: Most common adverse reactions in REDEMPLO treated patients (incidence ≥10% of patients treated with REDEMPLO and >5% more frequently than with placebo) are hyperglycemia, headache, nausea, and injection site reaction.

Please see full Prescribing Information for REDEMPLO.

arrowhead pharmaceuticals

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