Tryngolza™ (olezarsen) 80 mg injection

PATIENT ENROLLMENT AND PRESCRIPTION FORM

Fax: 877-914-0660 | Phone: 844-789-8744
Hours of Operations: Monday - Friday, 8 AM to 8 PM ET

IONIS EVERY STEP™ SUPPORT SERVICES

Complete this form for each patient, fields in red with asterisks are required.*

1 PATIENT INFORMATION

Patient First Name*: _____ Last Name*: _____ DOB*: ___/___/___ Gender: ☐ Male ☐ Female

Street Address*: _____ City*: _____ State*: _____ ZIP Code*: _____

Primary Phone #* (mobile preferred): _____ Alternative #: _____

Email: _____ Language: ☐ English ☐ Spanish ☐ Other _____

Alternate Contact / Care Partner Full Name: _____ Relationship to Patient: _____

Phone #: _____ Email: _____

2 PRESCRIBER INFORMATION

Prescribing Provider Name*: _____ Specialty: _____ ☐ Lipid Specialty

Practice Name: _____ Office Contact Name: _____

Practice Address*: _____ City*: _____ State*: _____ ZIP Code*: _____

Office Phone #*: _____ Office Fax #*: _____ Email: _____

Prescribing Provider NPI #*: _____

3 DIAGNOSIS AND CLINICAL INFORMATION

Attach copy of triglyceride tests, past and current medications, drug allergies, and acute pancreatitis history

Indication*: ☐ Familial Chylomicronemia Syndrome (FCS) ☐ Other _____

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

4 TRYNGOLZA™ PRESCRIPTION INFORMATION

Prescriber Instructions: Comply with State-specific requirements such as e-prescribing, state specific prescription form, fax language, etc. Either (1) fill out the information below and provide signature, or (2) send the prescription electronically to PANTHERx Specialty Pharmacy

Rx: TRYNGOLZA™ (olezarsen) injection, 80 mg/0.8 mL single-dose autoinjector 10-digit NDC: 71860-101-01

Dosing: ☐ Administer 80 mg subcutaneously once monthly OR ☐ Other dosing instructions: _____

Quantity = QS for 30 days supply OR Other quantity: _____ Refills:_____ ☐ Dispense as written

Quick Start: If eligible and when all information required for prior authorization is received, patient will be enrolled in Quick Start program that will provide free drug during the insurance approval process. The Quick Start program is available to all insured patients who are US residents with a diagnosis of familial chylomicronemia syndrome (FCS). Eligibility is subject to the terms and conditions of the program. Ionis Pharmaceuticals® reserves the right to rescind, revoke, or amend the program at any time without notice.

☐ I request for my patient **NOT** be provided Quick Start

By signing this form, I am indicating a prescribing decision has been made. In addition, I am certifying treatment with TRYNGOLZA™ 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 Ionis Every Step™ 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. For Quick Start: I understand that this medication is being provided free to the named patient by Ionis and agree that neither I nor the patient will bill an insurer or any government healthcare program for the cost of this medication. The program may not be combined with another offer and is not eligible to patients without insurance or whose insurer has made a final coverage determination.

_____ ____/____/____

Prescriber Signature *(Physician attests this is his/her legal signature. NO STAMPS)* MM/DD/YYYY

Attention: NY providers, please submit electronic prescriptions.

Please see Indication & Important Safety Information on page 3 and full Prescribing Information for TRYNGOLZA, also available at TRYNGOLZAhcp.com

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5 INSURANCE INFORMATION

☐ Patient is uninsured

	Medical Insurance	Prescription Insurance	
Insurance Provider			
Insurance Phone #			
Cardholder Name (if not patient)			
Cardholder DOB			
Policy #			
Group #		Rx Group #:	
Identifier	Member ID:	RxBIN: RxPCN:	

*Please include front and back copies of all insurance cards**

*Please provide copies of all insurance cards with the submission of this form

6 PATIENT AUTHORIZATION AND CONSENT

By signing this Patient Authorization and Consent form, I certify that I have read and understand the Authorization for Use and Disclosure of Protected Health Information and Consent to Receive Communications and agree to the terms. I understand that I am entitled to a copy of this Authorization and Consent upon request.

_____ ____/____/____ _____

Patient/Designated Representative Signature MM/DD/YYYY Printed Patient/Designated Representative Name *(If applicable)*

If signed by a designated representative, please indicate below the authority to act on behalf of the patient:

☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my health care providers ("HCPs"), my health plan, and my pharmacies, and each of their respective agents, to use and share my Protected Health Information (my "Information") with Ionis Pharmaceuticals and its affiliates, agents, and representatives. My Information includes my prescription-related health records, information about my health care plan benefits, demographic, contact, and any other information bearing on my health. My Information may be used to verify treatment and payment decisions with my HCPs; investigate and assist with coordination of coverage for Ionis medicines; coordinate prescription fulfillment and financial assistance; coordinate the provision of patient educational support, perform internal analysis at Ionis to better meet patient needs; and perform research and analysis of non-identified data for the purposes of measuring health outcomes.

PATIENT CONSENT TO IONIS COMMUNICATIONS

I understand and agree that Ionis may contact me, including by mail, email, telephone (including voicemail), and text messaging for educational and marketing purposes, including contacting me for market research purposes about Ionis therapies or Ionis. I understand and agree that any information that I provide may be used by Ionis to help develop new products, services, and programs.

I understand that federal privacy laws may not protect my Information once it is disclosed; however, Ionis agrees to protect my Information by using and disclosing it only for the purposes specified herein.

I understand that I can refuse to sign this Authorization and that my refusal will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. However, if I do not sign this Authorization, I will not be able to receive Ionis Patient Services support.

I understand that I may cancel this authorization at any time by calling Ionis Every Step Program at 844-789-8744. I understand that I am unable to cancel this authorization by mail or Email, and this must be done by phone. I understand that any such cancellation will not apply to any information already used or disclosed based on this Authorization prior to Ionis's receipt of the cancellation. This Authorization expires ten (10) years from the date unless a shorter period is required by law. The Ionis Privacy Policy may be found at https://www.ionis.com/privacy-policy.

INDICATION & IMPORTANT SAFETY INFORMATION FOR TRYNGOLZA

INDICATION
TRYNGOLZA (olezarsen) is indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS).

IMPORTANT SAFETY INFORMATION
CONTRAINDICATIONS
TRYNGOLZA is contraindicated in patients with a history of serious hypersensitivity to TRYNGOLZA or any of the excipients in TRYNGOLZA. Hypersensitivity reactions requiring medical treatment have occurred.

WARNINGS AND PRECAUTIONS
Hypersensitivity Reactions
Hypersensitivity reactions (including symptoms of bronchospasm, diffuse erythema, facial swelling, urticaria, chills, and myalgias) have been reported in patients treated with TRYNGOLZA. Advise patients on the signs and symptoms of hypersensitivity reactions and instruct patients to promptly seek medical attention and discontinue use of TRYNGOLZA if hypersensitivity reactions occur.

ADVERSE REACTIONS
Most common adverse reactions (incidence >5% of TRYNGOLZA-treated patients and >3% higher frequency than placebo) were injection site reactions, decreased platelet count, and arthralgia.

Please see full Prescribing Information for TRYNGOLZA

IONIS®
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