Prescription Start Form

Phone: 1-866- AKCEATX (1-866-252-3289) **Fax:** 1-866-AKCEAFX (1-866-252-3239)
Email: AkceaConnect@akceatx.com

AKCEA® CONNECT

Tegsedi® (inotersen) injection 284 mg/1.5 mL

All fields mandatory

1. PATIENT INFORMATION

First Name	Middle Initial	Last Name	Date of Birth (mm/dd/yyyy)	Gender ☐ M ☐ F
Home Address			City	
State	ZIP Code	Last four digits of SS# XXX-XX-		
Shipping Address (If Not Home Address)				
Care of (If different than Pt.)	City		State	ZIP Code
Home Phone # ☐ OK to leave Message	Mobile # ☐ OK to Text	Best Time to Call	Preferred Language (If other than English)	
Email Address	Pt. Representative/ Caregiver Name			
Relationship	Pt. Rep Phone #	Pt. Rep Email Address		

2. INSURANCE INFORMATION: (Please include front and back copies of 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/ Facility Name	
National Provider ID (NPI) #	Tax ID #	State License #	Phone #
Address			
City		State	ZIP Code
Office Contact	Contact Phone #		Office Fax #
Email Address		Preferred Method of Contact	

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

Primary Diagnosis: ☐ Hereditary Transthyretin Amyloidosis (ATTR) ☐ Other Diagnosis/Code _____

check shgain#####

☐ 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** _____