

Prescription Start Form

Phone: 1-866- AKCEATX (1-866-252-3289) **Fax:** 1-866-AKCEAFX (1-866-252-3239)

Email: AkceaConnect@akceatx.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-XXXX		
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 #			Pt. Rep Email Address				
2. INSURANCE INFORMATION: (Please include front and back copies of insurance cards) If no insurance please check here <input type="checkbox"/>									
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: <input type="checkbox"/> Hereditary Transthyretin Amyloidosis (MIM# 107785.1) <input checked="" type="checkbox"/> Other Diagnosis/Code <u>H0CF6JHC##</u>									
<input type="checkbox"/> NKDA Allergies _____									
Concurrent Medications _____									
<input type="checkbox"/> 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 <input type="checkbox"/> Once weekly <input type="checkbox"/> 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) <u>X</u> _____ Date _____									
Prescriber Signature (Substitution Allowed) <u>X</u> _____ Date _____									
Supervising Physician Signature (where required) <u>X</u> _____ 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.

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.

5. LABORATORY TESTING AND MEDICAL HISTORY

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

Platelets ≥ 100 x 10 ⁹ /L	Y <input type="checkbox"/> N <input type="checkbox"/>	Date drawn _____	UPCR < 1000 mg/g	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 _____		

History of:

Polyneuropathy	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: G63)
Bil. Carpal Tunnel Syndrome	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: G56.03)
Cardiomyopathy	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: I43)
Syncope	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: R55)
Cardiac Arrhythmia	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: I49.9)
Congestive Heart Failure	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: I50.9)
Transplant History	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: Z94)
Transplant Type: _____		

Diarrhea	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: K59.1)
Constipation	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: K59.00)
Unexplained Weight Loss	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: R63.4)
Renal Nephropathy	Y <input type="checkbox"/> N <input type="checkbox"/>	(ICD-10: N29)
Vitreous opacities	Y <input type="checkbox"/> N <input type="checkbox"/>	
Autonomic Dysfunctions	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ambulatory Status:		
Unassisted <input type="checkbox"/>	Cane <input type="checkbox"/>	Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/>

6. CURRENT AND HISTORICAL MEDICATIONS

Diflunisal <input type="checkbox"/> Current? Y <input type="checkbox"/> N <input type="checkbox"/> Duration of therapy _____ Tafamidis <input type="checkbox"/> Current? Y <input type="checkbox"/> N <input type="checkbox"/> Duration of therapy _____ Patisiran <input type="checkbox"/> Current? Y <input type="checkbox"/> N <input type="checkbox"/> Duration of therapy _____	Other <input type="checkbox"/> _____ _____ _____
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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 Akcea make no representations or warranties as to the accuracy of the information provided.

I authorize AKCEA CONNECT Program its affiliates, agents, and contractors (collectively, Akcea) 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.

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 _____

Please see full Prescribing Information for TEGSEDI, including boxed WARNING regarding the risk of thrombocytopenia and glomerulonephritis, at TEGSEDIhcp.com.

Patients should alert Accredo with any changes in status or insurance.