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# 72126-007-01 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** _____

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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 10^9/L and a UPCR ≥ 1000 mg/g.

Platelets ≥ 100 x 10^9/L Y ☐ N ☐ Date drawn _____

UPCR < 1000 mg/g Y ☐ N ☐ 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 ☐	N ☐	(ICD-10: G63)
Bil. Carpal Tunnel Syndrome	Y ☐	N ☐	(ICD-10: G56.03)
Cardiomyopathy	Y ☐	N ☐	(ICD-10: I43)
Syncope	Y ☐	N ☐	(ICD-10: R55)
Cardiac Arrhythmia	Y ☐	N ☐	(ICD-10: I49.9)
Congestive Heart Failure	Y ☐	N ☐	(ICD-10: I50.9)
Transplant History	Y ☐	N ☐	(ICD-10: Z94)

Transplant Type: _____

Diarrhea	Y ☐	N ☐	(ICD-10: K59.1)
Constipation	Y ☐	N ☐	(ICD-10: K59.00)
Unexplained Weight Loss	Y ☐	N ☐	(ICD-10: R63.4)
Renal Nephropathy	Y ☐	N ☐	(ICD-10: N29)
Vitreous opacities	Y ☐	N ☐	
Autonomic Dysfunctions	Y ☐	N ☐	

Ambulatory Status:

Unassisted ☐ Cane ☐ Walker ☐ Wheelchair ☐

6. CURRENT AND HISTORICAL MEDICATIONS

Diflunisal ☐ Current? Y ☐ N ☐ Duration of therapy _____

Tafamidis ☐ Current? Y ☐ N ☐ Duration of therapy _____

Patisiran ☐ Current? Y ☐ N ☐ Duration of therapy _____

Other ☐ _____

_____

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 X _____ **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.