

## ATTRUBY ENROLLMENT FORM

(acoramidis)

### 1 PATIENT INFORMATION (Please attach demographic information)

Patient Name (First, MI, Last): \_\_\_\_\_ Gender: Male Female  
 DOB (mm/dd/yyyy): \_\_\_\_\_ Email: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_  OK to leave message Language Preference: \_\_\_\_\_  
 Patient Caregiver Caregiver Name (First, MI, Last): \_\_\_\_\_ Caregiver Phone #: \_\_\_\_\_

### 2 INSURANCE INFORMATION (Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.)

Check here if patient does not have insurance  Check here if patient has secondary insurance  
 Primary Insurance Name: \_\_\_\_\_ Primary Insurance Phone #: \_\_\_\_\_  
 Policy/Group #: \_\_\_\_\_ Primary Policyholder Name (First, MI, Last) (if other than patient): \_\_\_\_\_  
 Primary Policyholder Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Primary Policyholder Relationship to Patient: \_\_\_\_\_  
 Prescription (Rx) Insurance Name (if applicable): \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Rx Bin #: \_\_\_\_\_

*If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address\*:*

### 3 PRESCRIBER INFORMATION

HCP Name (First, MI, Last): \_\_\_\_\_ Practice Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_ NPI #: \_\_\_\_\_ State License #: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_ Office Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### 4 PRESCRIPTION INFORMATION

#### ATTRUBY 356mg tablets (supplied as a carton of 112 tablets: 4 blister cards each containing 28 tablets)

I confirm that my patient is being prescribed ATTRUBY for treatment of ATTR-CM (Please fax clinical documentation to pharmacy along with enrollment form)

Primary ICD-10 Code: \_\_\_\_\_ Secondary ICD-10 Code(s): \_\_\_\_\_

ATTRUBY: Take 712 mg (two 356-mg tablets) orally twice daily with or without food. Quantity: 112 tablets (28 days). Refills: \_\_\_\_\_

Alternative Dosing: ATTRUBY: Take \_\_\_ capsules \_\_\_ times/day. Quantity: # \_\_\_ ( \_\_\_ days) Refills: \_\_\_\_\_

Drug Allergies: No Yes (If yes, please list medication(s) and associated reaction(s)): \_\_\_\_\_

Patient's Concurrent Medications: \_\_\_\_\_

### PRESCRIBER SIGNATURE

Product Substitution Permitted Signature

Date of Signature

Dispense as Written Signature

Date of Signature

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