IMCIVREE® (setmelanotide) injection | Rhythm InTune Support made personal

Start Form Guide

Fax forms to 1-877-805-0130
Phone: 1-855-206-0815
Email: patientsupport@rhythmtx.com

This form serves as your patient's prescription and provides an opportunity for your patient to enroll in Rhythm InTune, a support program from Rhythm Pharmaceuticals. When patients enroll, we can help them:

- Understand insurance coverage
- Get started on treatment
- Explore financial support options
- Access educational resources

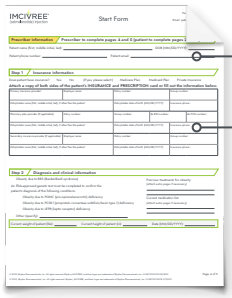
Questions?

If you have any questions about IMCIVREE or completing the Start Form, we're ready to help. Email us at patientsupport@rhythmtx.com or give us a call at **1-855-206-0815**, Monday–Friday, 8 AM to 6 PM ET.

To complete the Start Form, please follow these steps:

Patient or legally authorized representative to complete pages 2 and 3.

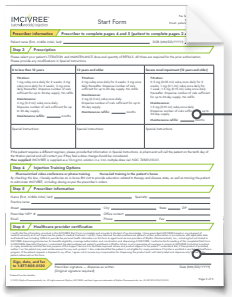
- Complete the **patient information** section. This section includes your patient's Rhythm InTune consent, which needs to be completed for your patient to receive the program benefits.
- To participate in Rhythm InTune, **check the box** on page 2 and **sign and date** the Consent Form on page 3.



Prescriber to complete pages 4 and 5. Fill in all requested information in Steps 1 through 5.

- Include copies of the front and back of the **patient's insurance and prescription cards**.
- **Genetic testing is not required to prescribe IMCIVREE to patients with Bardet-Biedl syndrome.**

  In patients aged 6+ years with obesity due to POMC, PCSK1, and LEPR deficiency, diagnosis must be confirmed with an FDA-approved genetic test. **Please provide a copy of the patient's results from an FDA-approved test. If you have questions or require more information, please call 1-855-206-0815.**
- In Step 3, be sure to check the appropriate boxes for your **patient's age**, **titration dose**, and **maximum dose**. This information ensures prior authorizations are requested for the patient's intended regimen. You can also request in-home or virtual injection training from the pharmacy on this page.
- **Sign and date** the Physician Certification.



Submit the completed form

Fax all completed pages to **1-877-805-0130**.

Remind your patient to expect a call from Rhythm InTune, the Patient Support Program. A representative from the program will call to confirm the patient's contact and insurance information. That call may come from an unfamiliar number. It is important that the patient answers the call to avoid delays in processing the prescription.

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Consent for Support Services

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Email: patientsupport@rhythmtx.com

Patient information — Patient or legally authorized representative to complete this page

Patient name (first, middle initial, last): _____

Date of birth (MM/DD/YYYY): _____

Last 4 digits of patient SSN: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Non-binary

Street: _____ City: _____ State: ____ ZIP: _____

Home phone: _____ Cell phone: _____

Preferred: ☐ Home ☐ Cell

☐ OK to leave a detailed message? ☐ OK to send a text?

Email: _____

Name of person completing form: _____

Relationship to patient: _____ Phone: _____

Section A — Consent for support services

Check this box ☐

I (or my representative) am electing to enroll in Rhythm InTune ("Services") and agree to the use and disclosure of my information in connection with such Services (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, and other related programs) and to communicate educational and/or promotional information to me about IMCIVREE and related Rhythm products and services. I authorize Rhythm, and its representatives, agents, and contractors to provide me with Services. I also authorize Rhythm to contact me or my physician by mail, email, or telephone in connection with the Services. The Company may also share information with my healthcare team for my care.

For additional information regarding how your information may be used, and how to contact Rhythm with questions or to exercise your rights, please review the Rhythm Privacy Policy (https://www.rhythmtx.com/privacy-policy) or email us at PatientSupport@rhythmtx.com.

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Email: patientsupport@rhythmtx.com

Patient information | **Patient or legally authorized representative to complete this page**

Patient name (first, middle initial, last): _____

Date of birth (MM/DD/YYYY): _____

Section B | Patient or legal representative authorization to use and share personal health information

I authorize any health plan, physician, healthcare professional, hospital, clinic, pharmacy provider, or other healthcare provider (collectively, "Providers") to disclose my personal health information, including personal information relating to my medical condition, genetic test results, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Rhythm Pharmaceuticals, Inc., its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Rhythm") in connection with the Company's provision of products, supplies, or services. I authorize the company to provide this information, and any specific information related to my prescription that I provide to the Company directly, to a specialty pharmacy to fulfill the prescription. Further, my Providers and the Company may use and disclose this Information for Rhythm InTune Support Services (if I agree above) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, other related programs, and communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance. This Information may also be used for internal purposes by the Company, including data analysis, or to improve, develop, and evaluate products, services, and programs related to my condition. I also authorize the Company to use my Information to provide me with educational and/or promotional information about IMCIVREE and related Rhythm products and services, adherence reminders and support and disease education, and to contact me to conduct market research. I understand that the specialty pharmacy may receive payment for activities described in this authorization. I understand that once disclosed to the Company, my Information disclosed under this Authorization may no longer be protected by federal privacy law, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to Rhythm Pharmaceuticals, Inc., 222 Berkeley Street, 12th Floor, Boston, MA 02116. I understand that such revocation will not apply to any Information already used or disclosed through this Authorization. I understand that revoking my Authorization will end my participation in the Rhythm InTune Support Services. This Authorization will remain in effect for five (5) years from today's date, unless a shorter period is provided for by state law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive Rhythm InTune Support Services.

Sign and date here

_____	_____
Patient/legal representative signature	Date (MM/DD/YYYY)
_____	_____
Patient name	Legal representative name and relationship

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Prescriber information | Prescriber to complete pages 4 and 5 (patient to complete pages 2 and 3)

Patient name (first, middle initial, last): _____ DOB (MM/DD/YYYY): _____

Patient phone number: _____ Patient email: _____

Step 1 | Insurance information

Does patient have insurance? ☐ Yes ☐ No (If yes, please select:) ☐ Medicare Plan ☐ Medicaid Plan ☐ Private Insurance

Attach a copy of both sides of the patient's INSURANCE and PRESCRIPTION card or fill out the information below.

Primary insurance provider:	Employer name:	Policy number:	Group number:	
Policyholder name (first, middle initial, last), if other than the patient:		Policyholder date of birth (MM/DD/YYYY):	Insurance phone:	
Pharmacy plan provider (if applicable):	Policy number:	Group number:	Rx BIN number:	Rx PCN number:
Policyholder name (first, middle initial, last), if other than the patient:		Policyholder date of birth (MM/DD/YYYY):	Insurance phone:	
Secondary insurance provider (if applicable):	Employer name:	Policy number:	Group number:	
Policyholder name (first, middle initial, last), if other than the patient:		Policyholder date of birth (MM/DD/YYYY):	Insurance phone:	

Step 2 | Diagnosis and clinical information

☐ Obesity due to BBS (Bardet-Biedl syndrome)

An FDA-approved genetic test must be completed to confirm the patient's diagnosis of the following conditions:

- ☐ Obesity due to POMC (pro-opiomelanocortin) deficiency
- ☐ Obesity due to PCSK1 (proprotein convertase subtilisin/kexin type 1) deficiency
- ☐ Obesity due to LEPR (leptin receptor) deficiency

☐ Other (specify): _____

Previous treatments for obesity:
(attach extra page if necessary)

_____

_____

Current medication list:
(attach extra page if necessary)

_____

_____

Current weight of patient (lbs): _____ Current height of patient (in): _____ Date (MM/DD/YYYY): _____

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Prescriber information | **Prescriber to complete pages 4 and 5 (patient to complete pages 2 and 3)**

Patient name (first, middle initial, last): _____ DOB (MM/DD/YYYY): _____

Step 3 Prescription

Please select your patient's TITRATION and MAINTENANCE dose and quantity of REFILLS. All three are required for the prior authorization. Please provide any modifications in Special Instructions.

6 to less than 12 years	12 years and older	Severe renal impairment (12 years and older)
☐ **Titration:** 1 mg subq once daily for 2 weeks; 2 mg subq once daily for 2 weeks; 3 mg once daily thereafter. Dispense number of vials sufficient for up to 30-day supply. No refills. ☐ **Maintenance:** 3 mg (0.3 mL) subq once daily. Dispense number of vials sufficient for up to 30-day supply. **Maintenance refills:** _____ months	☐ **Titration:** 2 mg subq once daily for 2 weeks; 3 mg once daily thereafter. Dispense number of vials sufficient for up to 30-day supply. No refills. ☐ **Maintenance:** 3 mg (0.3 mL) subq once daily. Dispense number of vials sufficient for up to 30-day supply. **Maintenance refills:** _____ months	☐ **Titration:** 0.5 mg (0.05 mL) subq once daily for 2 weeks; 1 mg (0.1 mL) subq once daily for 1 week; 1.5 mg (0.15 mL) subq once daily thereafter. Dispense number of vials sufficient for up to 30-day supply. No refills. ☐ **Maintenance:** 1.5 mg (0.15 mL) subq once daily. Dispense number of vials sufficient for up to 30-day supply. **Maintenance refills:** _____ months
Special Instructions:	Special Instructions:	Special Instructions:

If the patient requires a different regimen, please provide that information in Special Instructions. A pharmacist will call the patient on the tenth day of the titration period and will contact you if they feel a dose change should be considered.

How supplied: IMCIVREE is supplied as a 10-mg/mL solution in a 1-mL multiple-dose vial: NDC 72829-010-01.

Step 4 Injection Training Options

☐ **Pharmacist-led video conference or phone training provided by PANTHERx Specialty Pharmacy**

☐ **Nurse-led training in the patient's home** *By checking this box, I hereby authorize PANTHERx Specialty Pharmacy to provide an in-home RN visit through their contracted network to provide education related to therapy and disease state, as well as training the patient to administer IMCIVREE, including dosing as per the prescriber's orders.*

Step 5 Prescriber information

Name (first, middle initial, last): _____ Specialty: _____

Practice name: _____

Street: _____ City: _____ State: _____ ZIP: _____

Prescriber NPI* #: _____ Office contact: _____

Email: _____ Phone: _____ Fax: _____

Step 6 Healthcare provider certification

I certify that the information provided in this IMCIVREE Start Form is complete and accurate to the best of my knowledge. I have prescribed IMCIVREE based on my judgment of medical necessity and I will supervise the patient's medical treatment. I certify I have obtained the above-referenced patient's written authorization in accordance with applicable state and federal laws including HIPAA to provide the personal health information on this form to agents and service providers of Rhythm Pharmaceuticals, Inc., including but not limited to IMCIVREE dispensing pharmacies, for benefits eligibility, coverage authorization and coordination and dispensing of IMCIVREE. I authorize the forwarding of this completed Start Form to PANTHERx Specialty Pharmacy. I understand the above-referenced patient's enrollment in Rhythm InTune is not a guarantee of coverage or access to IMCIVREE (including to patient or copay assistance) and that the sole purpose of this Support Service is to facilitate improved access and product support to the patient. I understand that, if free product is provided, neither I nor the patient may seek reimbursement for any such product. I also understand that the patient is not eligible for copay assistance if he/she is enrolled in any federal healthcare program. If the patient requests a shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient referenced on this form.

Sign, date, and fax to 1-877-805-0130

_____

Prescriber signature — dispense as written
(Original signature required)

Date (MM/DD/YYYY)

*National Provider Identifier.