Patient Copay Reimbursement Form

This Reimbursement Form allows patients to receive reimbursement for an Alnylam product as well as applicable administration costs.* To receive your reimbursement:

1. Complete all required fields on this form. Submit one form for each treatment date.
2. Include a copy of your pharmacy receipt, Explanation of Benefits (EOB), or billing statement, representing the date of administration when you received an Alnylam product.
3. Fax, email or mail your pharmacy receipt, EOB, or billing statement along with this completed form to:
   Email: AlnylamCopay@UBC.com
   Fax: 800-984-8816
   Mail: Alnylam Assist® Copay Program
   680 Century Point
   Suite 1000
   Lake Mary, FL 32746
4. After your claim is received and processed, please allow 3-5 business days for the delivery of your check via email.
5. Reimbursement offer valid for an Alnylam product and applicable administration costs*, purchased in the United States. Completed requests must be postmarked within 180 days of date of administration.

If you have questions, please contact Alnylam Assist® Copay Program Support at 844-985-4498

Patient Information

Name (First, Middle, Last):

Date of Birth (mm/dd/yyyy):	Copay Member #:	
Street Address	City, State:	ZIP:

Email Address

Signature	Date

By signing above, I confirm that I meet the eligibility criteria, terms and conditions on page 2 associated with the Alnylam Assist® Copay Program, and that my Alnylam product is not covered by Medicare, Medicaid, TRICARE, DOD, IHS, VA, or any other state or federal healthcare or pharmaceutical assistance program.

See page 2 for terms and conditions.

*Out-of-pocket costs for the administration of an Alnylam product will not be covered for patients residing where it is prohibited by law or where otherwise restricted.

Terms and Conditions

(1) By using this copay card, you acknowledge that patient currently meets the eligibility criteria and will comply with the terms and conditions described below. (2) Patient must have a valid prescription for an Alnylam product (3) Valid only for those with commercial insurance. (4) Program has an annual benefit cap. (5) Patient is responsible for any costs once limit is reached in a calendar year. (6) Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, Indian Health Services (IHS), or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. (7) The value of this Program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, deductibles and any programs offered by a third party payer or pharmacy benefit manager, or an agent of either, that adjusts patient cost-sharing obligations, through arrangements that may be referred to as "accumulator" or "maximizer" programs. (8) Program is not valid where prohibited by federal and state laws. 9) Patient may not seek reimbursement for the value received from this Program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. (10) Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. (11) Valid only in the United States and US territories. (12) This Program is not health insurance. (13) Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. (14) This copay card will be accepted only at participating pharmacies. (15) Patient must be 18 years of age or older to redeem the copay card. (16) Alnylam reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice. (17) Data related to the redemption of the copay card may be collected, analyzed, and shared with Alnylam, for market research and other purposes related to assessing Alnylam's programs. Data shared with Alnylam will be aggregated and de-identified; it will be combined with data related to other copay card redemptions and will not identify patient. (18) Pharmacist Instructions: This card must be accompanied by a valid prescription for an Alnylam product.
Please submit the copay authorized by patient's primary insurance as a secondary transaction. Pharmacists with questions, please call CapitalRx at 1-844-306-9173.