Provider Form for Medical Copay Claim Reimbursement

This Reimbursement Form allows healthcare providers 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 patient, for each date of service.
2. Include a copy of the Explanation of Benefits (EOB) or billing statement, representing the date of administration for an Alnylam product.
3. Fax or email this completed form along with a copy of the EOB or billing statement to:
   Alnylam Assist® Copay Program
   Email: AlnylamCopay@UBC.com
   Fax: 800-984-8816
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

1. Patient Information

Name (First, Middle, Last):

Street Address	City, State:	ZIP:
Date of Birth (mm/dd/yyyy):	Copay Member #:	Date of Service:
Admin/CPT Code:	J Code:	NDC:
Billed Dollar Amount:	Copay Dollar Amount:	ICD-10-CM:

2. Provider Billing Information

Payment for Provider Reimbursements requests will be sent EFT to the bank account on file or to the email address indicated below.

Same as facility address: ☐ yes ☐ no

Facility / Office Name:	Attention To:

Street Address:

Suite #, etc.:	City, State:	ZIP:

Email Address:

Signature	Date

By signing above, I certify that I am a physician or healthcare provider authorized to sign on behalf of a physician that the patient meets the eligibility criteria, terms, and conditions on page 2, and I certify that all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that Alnylam is relying on this representation.

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

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.