Attruby™ (acoramidis) 356 mg tablet

forgingbridges™

SUPPORT PROGRAM START FORM

Scan with your mobile device to add ForgingBridges contact information

Questions? Call ForgingBridges at
1-888-55-BRIDGE (1-888-552-7434)
Mon–Fri, 8 AM to 8 PM ET
or visit **ForgingBridges.com**

SUBMISSION INSTRUCTIONS

Prescriber

Pages 2 and 3 of this Start Form should be completed and faxed to the number below. The following information is required for submission:

- Patient demographics
- A copy of your patient's insurance card
- Patient diagnosis (ICD-10-CM code)
- Attruby™ prescription
- Prescriber signature

Once completed, please fax the form to **1-877-738-0545**. ForgingBridges will confirm receipt with your office. Alternatively, eRx may be sent to the **RareMed Specialty Pharmacy (NPI: 1043877996).**

Note: If your patient is not present, the form may be submitted without their consent and signature. ForgingBridges will contact the patient to obtain this information.

Patient

Patient must choose one of the following 2 ways to provide their consent for enrollment:

- Complete the Patient Consent and Authorization section and sign on page 2 of this Start Form

OR

- Complete the Patient eConsent and Authorization at **ForgingBridges.iassist.com/patient** or by clicking/scanning the QR code below

Note: Patient consent and authorization signature is required for enrollment into the ForgingBridges Support Program but may be obtained after the form is submitted.

ICD-10-CM=*International Classification of Diseases, Tenth Revision, Clinical Modification*; NPI=National Provider Identifier.

Please click here for the ForgingBridges Support Program Terms and Conditions.
Please see full Prescribing Information for Attruby at Attruby.com/PI.

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Please fax pages 2 and 3 to 1-877-738-0545

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: ______________________ City: ______________ State: ______ ZIP: ________

Mobile Phone: ______________________ Alternate Phone: ______________________

Email Address: ____

Alternate Contact/Caregiver Name: ______________________ Phone: ______________________

Relationship to Patient: ____

Patient's Insurance: ☐ No insurance ☐ Copy of insurance and/or prescription card(s) attached

When submitting this form, provide a scanned copy of the front and back of the patient's insurance card, as applicable.

☐ Copy of patient's information attached (optional).

If this box is checked, please have patient review, sign, and date the "Patient Consent and Authorization" section below before completing page 3.

PATIENT CONSENT AND AUTHORIZATION

Patient consent to participate in ForgingBridges Support Program

By signing below, I certify that I have read the ForgingBridges Support Program Consent on page 4 and the **terms and conditions** and expressly consent to receive text messages regarding enrollment updates and alerts from ForgingBridges at the mobile telephone number that I provided above on this form, and I agree to notify ForgingBridges promptly if my number changes. I understand that message frequency varies by user, and my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by texting STOP to 1-888-552-7434 from my mobile phone or text HELP for additional support. If not signed below, I understand I will not receive text messages. Complete terms and our privacy policy can also be found at **ForgingBridges.com**. If applying for the ForgingBridges Patient Assistance Program (PAP), I also understand and grant permission to Experian to provide ForgingBridges with information from my credit/consumer profile for the sole purpose of determining if my income meets the eligibility requirements of the PAP.

Patient authorization to share Protected Health Information (PHI)

By signing below, I certify that I have read the authorization to share PHI on page 4, and I authorize the disclosure of my information to BridgeBio as described.

SIGN → Patient's Signature: ______________________________ Date: _____/_____/_____

If signed by authorized patient representative:

Authorized Patient Representative Name: ______________________________

Authorized Patient Representative Signature: ______________________ Date: _____/_____/_____

☐ Marketing consent (optional)

By checking this box, I additionally grant my authorization for BridgeBio to use my Protected Health Information (PHI) to communicate with me about the benefits of BridgeBio products and services, as described in the patient authorization to share and use PHI of this form. I specifically consent to receive autodialed marketing texts from BridgeBio and its service providers regarding BridgeBio products and services at the cell phone number provided on this form. I understand that providing this consent is not required or a condition of purchasing any products or services. I understand that I can opt out at any time.

Please click here for the ForgingBridges Support Program Terms and Conditions.
Please see full Prescribing Information for Attruby at Attruby.com/PI.

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Please fax pages 2 and 3 to 1-877-738-0545

Patient Name: ______________________ Patient Date of Birth: ___/___/______

PRESCRIBER INFORMATION

Prescriber Name: ______________ Prescriber Title: ______ Prescriber Phone: ______________ Prescriber NPI#: ______________

Facility Name: ______________ Address: ______________ City: ______________ State: ____ ZIP: ______

Office Contact Name: ______________ Phone: ______________ Email: ______________ Fax: ______________

PHARMACY AND CLINICAL INFORMATION

Dispensing Method (select one): ☐ Specialty Pharmacy ☐ Institutional/Hospital Specialty Pharmacy

Preferred Specialty Pharmacy (if applicable): ☐ Orsini ☐ PANTHERx Rare ☐ No Preference

☐ Institution/Hospital Specialty Pharmacy Name (if applicable): ______________ Phone: ______________

☐ New to Attruby™

Current or Previous Therapy:

☐ Tafamidis Dose: ______ Duration: ______

☐ Tafamidis meglumine Dose: ______ Duration: ______

☐ Other: ______ Dose: ______ Duration: ______

☐ None

ICD-10-CM Diagnosis Code (select one)*:

☐ E85.4: Organ-limited amyloidosis

☐ E85.82: Wild-type transthyretin-related (ATTR) amyloidosis

☐ E85.9: Amyloidosis, unspecified

☐ Other: ______________

Medication Allergies:

☐ Known Drug Allergies: ______________

☐ No Known Allergies

PRESCRIPTION INFORMATION

Attruby Prescription

Drug Name	Dosing Instructions	Quantity	Refills
☐ Attruby 356 mg tablets NDC: 82228-712-28	Take 2 tablets by mouth twice daily	Dispense 28-day supply	☐ 1 year ☐ Other: ______ refills

The Free Trial Program is available to patients with any form of insurance who are new to Attruby.

Attruby Free Trial Prescription

Drug Name	Dosing Instructions	Quantity	Refills
☐ Attruby 356 mg tablets NDC: 82228-712-28	Take 2 tablets by mouth twice daily	Dispense 28-day supply	0 refills

Wet signature required. If wet signature cannot be obtained, eRx may be sent to the RareMed Specialty Pharmacy (NPI: 1043877996).

SIGN **Prescriber's Signature (choose one):**

______________________ Date: ___/___/______
Dispense as Written†

______________________ Date: ___/___/______
Substitution Allowed‡

Any Special Instructions: ______________________

*Example ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.
†Certain states require "brand necessary" or "brand medically necessary" to be handwritten by the prescriber under "Any Special Instructions" if they have made this determination in their independent clinical judgment. Prescriber should comply with state-specific prescription requirements. Noncompliance could result in outreach to the prescriber.
‡Use the space under "Any Special Instructions" to include authorized substitutions.

Prescriber certification: My signature certifies that the patient named on this form is my patient, that the information provided by me in the form is, to the best of my knowledge, complete and accurate, and that therapy with Attruby is medically necessary for my patient. I certify that I have obtained from my patient written authorization, in accordance with all applicable state and federal law, to release the patient's individually identifiable health information included on this form to ForgingBridges and that such authorization permits ForgingBridges to contact the patient and otherwise the patient's individually identifiable information to (i) verify my patient's insurance coverage (including by sharing the information with the patient's insurance plan); (ii) determine my patient's eligibility for ForgingBridges benefits; and (iii) coordinating ForgingBridges programs for the benefit of my patient. For Specialty Pharmacy prescriptions, I authorize ForgingBridges to transmit the above prescription to the appropriate Specialty Pharmacy for my patient. I understand I am under no obligation to prescribe any BridgeBio product, and I certify that I have not received, nor will I receive, any benefit from BridgeBio for doing so. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will not seek reimbursement for any medication dispensed under the ForgingBridges program from any third-party payer, patient, or other person or entity. Any medication I receive on behalf of my patient from ForgingBridges will be appropriately secured and stored until it is dispensed at no charge to the above-named patient only, and will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I agree to comply with and abide by all applicable state practitioner dispensing laws for authorized prescribers. I attest I am not on the HHS/OIG list of excluded individuals. I understand that BridgeBio reserves the right to rescind, revoke, or amend the program and to discontinue support at any time without notice.

Special Note: New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.
HHS=US Department of Health and Human Services; OIG=Office of Inspector General.

Please click here for the ForgingBridges Support Program Terms and Conditions.
Please see full Prescribing Information for Attruby at Attruby.com/PI.

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You may print and keep a copy of this page for your records.

ForgingBridges Support Program patient consent

Please read the following consent carefully, and if you agree, sign and date where indicated in the Patient Consent and Authorization section on page 2.

By signing on page 2, I am agreeing to the **terms and conditions** for my enrollment in the ForgingBridges Support Program (the "Program"). I authorize BridgeBio Pharma Inc. ("BridgeBio"), the sponsor of the Program, and its affiliates, business partners, vendors, and other agents to provide me with services for which I am eligible under the Program. This may include medication and adherence communications and support, medication fulfillment and dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to the terms of enrollment in the Copay Assistance Program if I am eligible. If I am applying for the Patient Assistance Program, I authorize the Program to obtain a report on my individual income from consumer reporting agencies and to use information provided by me as sources to verify the information on this form to determine if I am eligible for free medication. I understand that, upon my request, the Program will provide me with the name and address of the consumer reporting agency that delivers any such consumer report. I authorize BridgeBio to contact me by mail, telephone, email, and if I grant my consent on page 2, also by text regarding: i) Program services; ii) information about BridgeBio's products; iii) promotions; iv) research studies; v) my opinion about such information and topics; vi) market research; and vii) disease-related surveys. I further authorize BridgeBio to de-identify my information and use it in performing research, education, business analytics, and marketing studies or for other commercial purposes. I understand I do not have to enroll in the Program, and I can still receive my medication as prescribed by my physician. I may at any time opt out of individual services offered by the Program or opt out of the Program entirely by notifying a Program representative by calling 1-888-55-BRIDGE (1-888-552-7434) or by writing to ForgingBridges at PO Box 15600, Pittsburgh, PA 15244. I understand the Program may be changed or discontinued in whole or in part by BridgeBio at any time.

ForgingBridges authorization to share Protected Health Information (PHI)

Please read the following authorization carefully, and if you agree, sign and date where indicated in the Patient Consent and Authorization section on page 2.

By signing the Patient Authorization section on page 2 of this form, I authorize my healthcare providers and staff, my pharmacies, and my health insurers to disclose to BridgeBio Pharma Inc. and its affiliates, business partners, vendors, and other agents involved in the ForgingBridges Support Program (the "Program") information identifiable to me, including (i) my contact information; (ii) my health information, such as information on my medical condition and treatment; (iii) health insurance and coverage claims; and (iv) prescription fulfillment information (collectively, my "Information"), to facilitate my receipt of benefits from the Program. I further authorize the Program to use my Information and to discuss it with my healthcare providers and insurers, as needed to enroll me in support programs, provide services, and conduct quality assurance and other administrative activities, and to contact me by mail, telephone, email, and if I grant my consent on page 2, also by text, regarding: i) Program services; ii) information about BridgeBio's products; iii) promotions; iv) research studies; v) my opinion about such information and topics; vi) market research; and vii) disease-related surveys. I further authorize BridgeBio to de-identify my information and to use the de-identified information in performing research, education, business analytics, and marketing studies or for other commercial purposes.

I understand that, once my Information has been disclosed to the Program, certain federal privacy laws may no longer protect the Information from further disclosure. However, I also understand BridgeBio intends to use and disclose my Information only for the purposes referenced in this authorization or as otherwise required or permitted by law. I understand the pharmacy that dispenses my medication may receive payment from BridgeBio in exchange for my information and/or for providing support services to me in relation to the Program. I understand I do not have to sign this authorization in order to obtain medical treatment from my healthcare providers, to be eligible for health insurance benefits, or to obtain BridgeBio's medications. However, if I do not sign this authorization, I understand I will not be able to participate in the Program. I understand that this authorization expires 10 years from the date signed below, or earlier as may be required by state or local law, and until I cancel this authorization before then. I may cancel this authorization at any time by calling 1-888-55-BRIDGE (1-888-552-7434) or by writing to ForgingBridges at PO Box 15600, Pittsburgh, PA 15244. I understand that cancellation of this authorization will not invalidate any uses and disclosures of my information made in reliance on the authorization before ForgingBridges' receipt of the cancellation. I understand I may request a signed copy of this authorization.

Please click here for the ForgingBridges Support Program Terms and Conditions.
Please see full Prescribing Information for Attruby at Attruby.com/PI.

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