IMCIVREE® setmelanotide injection | Rhythm InTune Support made personal

Email: Imcivree@bayshore.ca
Fax forms to: 1-833-350-3887
Phone: 1-833-654-2155

Enrolment Form Guide

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

Get started on treatment

Understand insurance coverage

Access educational resources

How to complete the Enrolment Form:

1. Prescriber completes pages 1 and 2.
2. Patient or legally authorized representative completes page 3.
3. Prescriber faxes or emails all completed pages to 1-833-350-3887 or Imcivree@bayshore.ca (Rhythm InTune).
4. 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 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.

Questions

Email us at Imcivree@bayshore.ca or call Rhythm InTune at 1-833-654-2155, 8am to 8pm EST.

Prescriber to complete | Diagnosis and clinical information

Patient name (first, middle initial, last): _____ Date of birth (DD/MM/YYYY): _____
Street: _____ City: _____ Province: _____ Postal Code: _____
Phone: _____ ☐ OK to leave a detailed message? Email: _____ ☐ OK to send an email?

Diagnosis:

☐ Obesity due to BBS (Bardet Biedl Syndrome)
☐ Obesity due to genetically confirmed biallelic POMC (pro-opiomelanocortin) deficiency
☐ Obesity due to genetically confirmed biallelic PCSK1 (proprotein convertase subtilisin/kexin type 1) deficiency
☐ Obesity due to genetically confirmed biallelic LEPR (leptin receptor) deficiency

Patient medically cleared to start medication: ☐ Yes ☐ No
Patient may start therapy on or after (DD/MM/YYYY): _____

☐ Previous treatments for weight management (attach extra page if needed): _____
Current medication list (attach extra page if needed): _____
_____
_____

Patient w eight: _____ kg Patient height: _____cm Patient BMI: _____
Date (DD/MM/YYYY): _____
Allergies: ☐ No ☐ Yes Specify: _____
Preferred language: ☐ English ☐ French Gender at birth: ☐ Male ☐ Female

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Prescription

Prescriber to complete this page

Patient name (first, middle initial, last): _____ Date of Birth (DD/MM/YYYY): _____

Please check the appropriate boxes for **TITRATION** and **MAINTENANCE** dose and fill in the number of REFILLS.
To modify the patient's regimen, call 1-833-654-2155.

6 to 17 years	18 years and older	Severe renal impairment*: ≥ 12 years
☐ **Titration:** In pediatric patients aged 6 to 17 years, the starting dose is 0.5 mg (0.05 mL), and the target dose is 2 mg (0.2 mL). • The starting dose of setmelanotide is 0.5 mg (0.05 mL) injected subcutaneously (SC) once daily (QD) for 2 weeks. • Monitor patients for gastrointestinal (GI) adverse reactions to adjust dosage. • The dose may be increased by 0.5 mg daily every 2 weeks if tolerated to a maximum dose of 2.0 mg daily. • If the starting dose is not tolerated, IMCIVREE should be discontinued.	☐ **Titration:** In adult patients 18 years of age and older, the starting dose is 1 mg (0.1 mL), and the target dose is 3 mg (0.3 mL). • The starting dose of setmelanotide is 1 mg (0.1 mL) injected subcutaneously (SC) once daily (QD) for 2 weeks. • Monitor patients for gastrointestinal (GI) adverse reactions to adjust dosage. • The dose may be increased by 0.5 mg daily every 2 weeks if tolerated to a maximum dose of 3.0 mg daily. • If the starting dose is not tolerated, IMCIVREE should be discontinued.	☐ **Titration:** For adults and pediatric patients 12 years of age and older with severe renal impairment (eGFR 15 to 29 mL/min/1.73 m^2) the starting dose is 0.5 mg (0.05 mL), and the target dose is 1.5 mg (0.15 mL). • The starting dose of setmelanotide is 0.5 mg (0.05 mL) injected subcutaneously (SC) for 2 weeks. Monitor patients for GI adverse reactions. • The dose may be increased by 0.5 mg daily every 2 weeks if tolerated to a maximum of 1.5 mg daily. • If the starting dose is not tolerated, IMCIVREE should be discontinued.
☐ **Maintenance:** 2 mg (0.2 mL) SC once daily. **Maintenance refills: ____ months**	☐ **Maintenance:** 3 mg (0.3 mL) SC once daily. **Maintenance refills: ____ months**	☐ **Maintenance:** 1.5 mg (0.15 mL) SC once daily. **Maintenance refills: ____ months**
Special instructions:	**Special instructions:**	**Special instructions:**

* Severe renal impairment = eGFR 15-29 mL/min/1.73 m^2. IMCIVREE is not recommended for use in patients with end-stage renal disease (eGFR less than 15 mL/min/1.73 m^2). If the patient requires a different regimen, please provide that information in Special Instructions. See the Product Monograph for full instructions on dosing and administration. 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 DIN 02537745.

Prescriber Information

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

Practice street address: _____ City: _____ Province: _____ Postal Code: _____

License number: _____ Email: _____ Phone: _____ Fax: _____

I certify that the information provided in this IMCIVREE Enrolment Form is complete and accurate to the best of my knowledge. I have prescribed IMCIVREE based on my judgment of medical necessity, as documented in the patient's medical record, 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 provincial, territorial and federal laws to provide the personal health information on this form to affiliates, 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 Rhythm InTune to forward this Enrolment Form (and the information included herein) by fax or other mode of delivery to Bayshore Specialty Pharmacy **[or the patient's other chosen pharmacy]**. This Enrolment Form represents the original prescription drug order. I understand that enrolment of the above-referenced patient in Rhythm InTune is not a guarantee of coverage or access to IMCIVREE (including to patient assistance or copay assistance) and that the sole purpose of this Support Service is to help to facilitate improved access and product support to the patient. I understand that, to the extent that any product is furnished to the patient without charge, neither I nor the patient may seek reimbursement for any such product. If the patient has requested a shipment to my office, I will clearly label and dispense only for use by the patient referenced on this application.

Sign, date, and fax to 1-833-350-3887

_____ Date (DD/MM/YYYY):_____

Prescriber signature – dispense as written
(original signature required)

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

Name of person completing form:_____ Relationship to patient:_____

Patient consent:

I (or my parent or other legal representative) am electing to enrol in Rhythm InTune Program ("Services") and agree to the collection, storage, 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. The Services are administered by a third party service provider, selected from time to time by Rhythm (the "Program Administrator"). I understand that Rhythm reserves the right to appoint third party Program Administrators to administer the Services and consent to my information being transferred to any future program administrator administering the 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 at rhythmtx.ca or email us at Imcivree@bayshore.ca.

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 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 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 PIPEDA. 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, USA. 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 federal and Provincial 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.

If applicable, I confirm that I am the parent or legal representative of the minor patient identified on this authorization, and by signing this authorization, I hereby consent to enrol the patient in the Services and to the collection, use and disclosure of Information described above.

_____
Patient name (if applicable)

_____
Legal representative name and relationship (if applicable)

_____
Date (DD/MM/YYYY)

☐ Signature consents to the above

_____
Patient/legal representative signature

☐ Verbal consent confirmed by prescriber (for virtual visits only)

_____
Prescriber signature