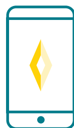
This form serves as your patient's prescription and provides an opportunity to enroll in IMCIVREE GPS, a support service from Rhythm Pharmaceuticals. When patients enroll, we can help them:

Understand their insurance benefits



Explore financial support options if they need help covering the cost of IMCIVREE

Provide additional educational information, including help learning to inject IMCIVREE

Questions?

If you have any questions about IMCIVREE or completing the Start Form, we're ready to help. Give us a call at **1-844-YOUR-GPS** (1-844-968-7477), Monday – Friday, 8 AM to 8 PM ET.

To complete the Start Form, please follow these steps:

Patient or legally authorized representative to complete page 2.

Complete **patient information** section. This section includes your patient's IMCIVREE GPS consent, which needs to be completed for your patient to receive the program benefits.

Sign and date the Consent Form to participate in IMCIVREE GPS.

Prescriber to complete pages 3 and 4. 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**.

Include a **copy of the patient's genetic test results**. IMCIVREE is indicated for chronic weight management in patients aged 6+ with obesity due to POMC, PCSK1, and LEPR deficiency confirmed by genetic testing. These diseases are biallelic, signifying that variants are present in both copies of the gene, and therefore include both homozygous and compound heterozygous forms. Financial support may be available to eligible patients for whom IMCIVREE treatment is indicated.

In Step 3, be sure to check the appropriate boxes for your **patient's age**, **titration dose**, and **maintenance dose**. This information ensures prior authorizations are requested for the patient's intended regimen.

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 IMCIVREE GPS, the IMCIVREE 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.

© 2021, Rhythm Pharmaceuticals, Inc. All rights reserved. Rhythm, IMCIVREE, and their logos are trademarks of Rhythm Pharmaceuticals, Inc. US-SET-2000078 10/2021

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 and educational information

☐ By checking this box, I (or my representative) am electing to enroll in the IMCIVREE GPS Support Services ("Services") and direct all disclosures 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 co-pays, patient assistance programs, alternate funding sources, and other related programs). 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.

☐ By checking this box, I (or my representative) also authorize Rhythm and certain authorized parties to send me educational communications such as mailings, emails, newsletters about the product or IMCIVREE GPS Support Services, or occasional communication for market research purposes to get your feedback on how to improve our services and content. I understand I may opt out of these communications at any time via the link/contact information available in all communications. This opt-in is not required to enroll in IMCIVREE GPS.

Section B — Authorization to share personal health information

Patient or legal representative authorization to 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 to a specialty pharmacy to fulfill the prescription.

Further, the Company may use and disclose this Information for IMCIVREE GPS Support Services (if I agree above) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, 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 understand that the specialty pharmacy may receive payment for the expense of assembling and sending data about me to the Company.

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 IMCIVREE GPS 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 IMCIVREE GPS Support Services.

Sign and date here

______________________ Patient/legal representative signature

______________________ Date (MM/DD/YYYY)

______________________ Patient name

______________________ Legal representative name and relationship

© 2021, Rhythm Pharmaceuticals, Inc. All rights reserved. Rhythm, IMCIVREE, and their logos are trademarks of Rhythm Pharmaceuticals, Inc. US-SET-2000078 10/2021

Prescriber information

Prescriber to complete pages 3 and 4 (patient to complete page 2)

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

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:	

Only patients with biallelic POMC, PCSK1, or LEPR deficiency confirmed by genetic testing will be eligible for co-pay and other financial support programs.

Step 2 Diagnosis and clinical information

A genetic test must be completed to confirm the patient's diagnosis. Please attach a copy of the genetic test results.

☐ Obesity due to POMC (proopiomelanocortin) deficiency

☐ Obesity due to PCSK1 (proprotein convertase subtilisin/kexin type 1) deficiency

☐ Obesity due to LEPR (leptin receptor) deficiency

☐ Other (specify): ______________________

Current weight of patient (lbs): ____________

Current height of patient (in): ____________

Date (MM/DD/YYYY): ____________

Previous treatments for obesity:

____

____

Current medication list (attach extra page if necessary):

____

____

Recommended dosing

Patient age	**Starting dose** Weeks 0 to 2	**Maintenance dose** Week 3 and beyond	
6 to less than 12 years	1 mg once daily	2 mg once daily	3 mg once daily *if 2 mg daily dose is tolerated and additional weight loss is desired*
12 years and older	2 mg once daily	3 mg once daily	

If a dose is not tolerated, reduce the dose. If the reduced dose is tolerated, consider titrating back to the recommended dose. See full Prescribing Information for additional details on dosing.

© 2021, Rhythm Pharmaceuticals, Inc. All rights reserved. Rhythm, IMCIVREE, and their logos are trademarks of Rhythm Pharmaceuticals, Inc. US-SET-2000078 10/2021

Prescriber information — Prescriber to complete pages 3 and 4 (patient to complete page 2)

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

Step 3 Prescription

Please check the appropriate boxes for your patient's **TITRATION** and **MAINTENANCE** dose and fill in the number of **REFILLS**. This information ensures prior authorizations are requested for the patient's intended regimen. The patient's regimen can be modified at any time by calling the pharmacy at 1-844-968-7477.

6 to less than 12 years	12 years and older
☐ **Titration:** 1 mg (0.1 mL) subq once daily for 2 weeks; 2 mg (0.2 mL) subq once daily for 2 weeks. Dispense number of vials sufficient for up to 30-day supply. No refills. ☐ **Maintenance:** 2 mg (0.2 mL) subq once daily. Dispense number of vials sufficient for up to 30-day supply. **Maintenance refills:** ________ months	☐ **Titration:** 2 mg (0.2 mL) subq once daily for 2 weeks; 3 mg (0.3 mL) subq once daily for 2 weeks. 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
Special Instructions:	Special Instructions:

If the patient does not require titration, or a different titration and/or maintenance regimen is required, please provide that information in Special Instructions.

Please note that a pharmacist will check in with 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 Prescriber information

Name (first, middle initial, last): ______________________ Specialty: ______________

Practice name: ______________________________________

Street: ______________________ City: ______________ State: ______ ZIP: __________

Prescriber NPI[†] #: ______________________________________

Office contact: ______________________ Phone: ______________ Fax: ______________

Step 5 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, 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 state and federal laws including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable 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 Start Form (and the information included herein) to PANTHERx Specialty Pharmacy. I understand that enrollment of the above-referenced patient in IMCIVREE GPS is not a guarantee of coverage or access to IMCIVREE (including to patient assistance or co-pay 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. I also understand that the patient is not eligible for co-pay assistance, should any be available, if he/she is enrolled in any federal healthcare program. If the patient has requested 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 application.

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

____

Prescriber signature — dispense as written (Original signature required) Date (MM/DD/YYYY)

[†]National Provider Identifier.

© 2021, Rhythm Pharmaceuticals, Inc. All rights reserved. Rhythm, IMCIVREE, and their logos are trademarks of Rhythm Pharmaceuticals, Inc. US-SET-2000078 10/2021