IMCIVREE® (setmelanotide) injection | Rhythm InTune Support made personal

Start Form Guide

Fax forms to 1-877-805-0130
Phone: 1-855-206-0815
Email: patientsupport@rhythmtx.com

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

- Understand insurance coverage
- Get started on treatment
- Explore financial support options
- Access educational resources

Questions?

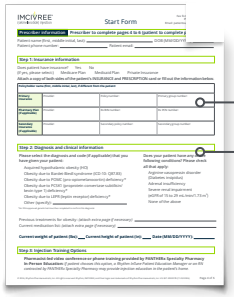
If you have any questions about IMCIVREE or completing the Start Form, we're ready to help. Email us at patientsupport@rhythmtx.com or give us a call at **1-855-206-0815**, Monday–Friday, 8 AM to 6 PM ET.

To complete the Start Form, please follow these steps:

Patient or legally authorized representative to complete pages 2 and 3.

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

To participate in Rhythm InTune, **check the box** on page 2 and **sign and date** the Consent Form on page 3.



Prescriber to complete pages 4 to 6. Fill in all requested information in Steps 1 through 6.

Include copies of the front and back of the **patient's insurance and prescription cards**.

Genetic testing is not required to prescribe IMCIVREE to patients with Bardet-Biedl syndrome or acquired hypothalamic obesity.

In patients aged 2+ years with obesity due to POMC, PCSK1, and LEPR deficiency, diagnosis must be confirmed with genetic testing. **Please provide a copy of the patient's results from genetic testing. If you have questions or require more information, please call 1-855-206-0815.**

You can also request in-home or virtual injection training on this page.

In Step 4, be sure to check the appropriate boxes for your **patient's age (and weight if applicable), titration dose**, and **maintenance dose**. This information is required to process the prescription.

After reviewing the attestation on page 6, **sign and date** the Physician Certification on page 5.

Submit the completed form

Fax all completed pages to **1-877-805-0130**.

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 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.

Rhythm PHARMACEUTICALS
Pioneering a path forward

US-SET-2000078 (11.03/2026)

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Consent for Support Services

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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 Race/Ethnicity: _____

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

Check this box ☐

I (or my representative) am electing to enroll in Rhythm InTune ("Services") and agree to the 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. I authorize Rhythm, and its representatives, agents, and contractors to provide me with Services and to use my information for this purpose. 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 (https://www.rhythmtx.com/privacy-policy) or email us at PatientSupport@rhythmtx.com.

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Patient information | **Patient or legally authorized representative to complete this page**

Patient initials: _____ Date of birth (MM/DD/YYYY): _____

Section B | Patient or legal representative authorization to use and 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 or 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") in connection with the Company's provision of products, supplies, or services. I authorize the Company to provide this information, and any specific information related to my prescription that I provide to the Company directly, 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 (Rhythm InTune) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, other related programs, and communication with me or my providers by mail, email, or telephone about my medical condition, treatment, care, 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 and/or promotional information about IMCIVREE and related Rhythm products and services, adherence reminders and support and disease education, and to contact me for market research. I understand that the specialty pharmacy may receive payment for activities described in this authorization. I understand that Rhythm may de-identify my Information, that this information may be combined with other de-identified information about me or others, and that the resulting information may be used for research or Rhythm's business purposes. 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 and that revoking my Authorization will end my participation in Rhythm InTune. 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 my refusal 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.

Sign and date here

_____ Patient/legal representative signature

_____ Date (MM/DD/YYYY)

_____ Patient name

_____ Legal representative name and relationship

Optional disclosure authorization:

I also authorize the disclosure of my personal health information to the following designated individual(s)

Name: _____ Relationship to patient: _____

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Prescriber information **Prescriber to complete pages 4 to 6 (patient to complete pages 2 and 3)**

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

Patient phone number: _____ Patient email: _____

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.

Policyholder name (first, middle initial, last), if different from the patient:			
Primary Insurance	Provider:	Policy number:	Primary group number:
Pharmacy Plan (if applicable)	Provider:	Rx BIN number:	Rx PCN number:
Secondary Insurance (if applicable)	Provider:	Secondary policy number:	Secondary group number:

Step 2: Diagnosis and clinical information

Please select the diagnosis and code (if applicable) that you have given your patient:

- ☐ Acquired hypothalamic obesity (HO)
- ☐ Obesity due to Bardet-Biedl syndrome (ICD-10: Q87.83)
- ☐ Obesity due to POMC (pro-opiomelanocortin) deficiency*
- ☐ Obesity due to PCSK1 (proprotein convertase subtilisin/kexin type 1) deficiency*
- ☐ Obesity due to LEPR (leptin receptor) deficiency*
- ☐ Other (specify): _____

*A genetic test must be completed to confirm this diagnosis

Does your patient have any of the following conditions? Please check all that apply:

- ☐ Arginine vasopressin disorder (Diabetes insipidus)
- ☐ Adrenal insufficiency
- ☐ Severe renal impairment (eGFR of 15 to 29 mL/min/1.73 m^2)
- ☐ None of the above

Previous treatments for obesity: *(attach extra page if necessary)* _____

Current medication list: *(attach extra page if necessary)* _____

Current weight of patient (lbs):____ Current height of patient (in):____ Date (MM/DD/YYYY):_____

Step 3: Injection Training Options

- ☐ **Pharmacist-led video conference or phone training provided by PANTHERx Specialty Pharmacy**
- ☐ **In-Person Education:** *If patient chooses this option, a Rhythm InTune Patient Education Manager or an RN contracted by PANTHERx Specialty Pharmacy may provide injection education in the patient's home.*

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Prescriber information **Prescriber to complete pages 4 to 6 (patient to complete pages 2 and 3)**

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

Step 4: Prescription

TITRATION and MAINTENANCE dose and quantity of REFILLS are required for prescription processing. Please provide any modifications in Special Instructions.

		Dose	Quantity	Refills
Acquired HO: 6 years and older				
	☐ **TITRATION**	0.5mg (0.05 mL) SubQ Qday × 2 weeks; 1mg (0.1 mL) SubQ Qday × 2 weeks; 2mg (0.2 mL) Qday × 2 weeks; 3mg (0.3 mL) Qday thereafter	30 day supply	0
	☐ **MAINTENANCE**	3mg (0.3 mL) SubQ Qday	30 day supply	___ months
BBS or POMC deficiency, PCSK1 deficiency, LEPR deficiency: 12 years and older				
	☐ **TITRATION**	2mg (0.2 mL) SubQ Qday × 2 weeks; 3mg (0.3 mL) Qday thereafter	30 day supply	0
	☐ **MAINTENANCE**	3mg (0.3 mL) SubQ Qday	30 day supply	___ months
BBS or POMC deficiency, PCSK1 deficiency, LEPR deficiency: 6 to less than 12 years				
	☐ **TITRATION**	1mg (0.1 mL) SubQ Qday × 2 weeks; 2mg (0.2 mL) Qday × 2 weeks; 3mg (0.3 mL) Qday thereafter	30 day supply	0
	☐ **MAINTENANCE**	3mg (0.3 mL) SubQ Qday	30 day supply	___ months
Acquired HO ages 4 to less than 6 years / BBS or POMC, PCSK1, LEPR deficiency ages 2 to less than 6 years (please note dosing for this group is weight-based)				
15 to <20kg Patient Weight	☐ **TITRATION & MAINTENANCE**	0.5mg (0.05 mL) SubQ Qday	30 day supply	___ months
20 to <30kg Patient Weight	☐ **TITRATION**	0.5mg (0.05 mL) SubQ Qday × 2 weeks; 1mg (0.1 mL) Qday thereafter	30 day supply	0
	☐ **MAINTENANCE**	1mg (0.1 mL) SubQ Qday	30 day supply	___ months
30 to <40kg Patient Weight	☐ **TITRATION**	0.5mg (0.05 mL) SubQ Qday × 2 weeks; 1mg (0.1 mL) Qday × 2 weeks; 1.5mg (0.15 mL) Qday thereafter	30 day supply	0
	☐ **MAINTENANCE**	1.5mg (0.15 mL) SubQ Q Day	30 day supply	___ months
≥40kg Patient Weight	☐ **TITRATION**	0.5mg (0.05 mL) SubQ Qday × 2 weeks; 1mg (0.1 mL) Qday × 2 weeks; 1.5mg (0.15 mL) Qday × 2 weeks; 2mg (0.2 mL) Qday thereafter	30 day supply	0
	☐ **MAINTENANCE**	2mg (0.2 mL) SubQ Qday	30 day supply	___ months

How supplied: IMCIVREE is supplied as a 10-mg/mL solution in a 1-mL multiple-dose vial: NDC 72829-010-01.

Special Instructions:

Step 5: Prescriber information

Name (first, middle initial, last): _____ Specialty: _____
Practice name: _____
Street: _____ City: _____ State: _____ ZIP: _____
Prescriber NPI* #: _____ Office contact: _____
Email: _____ Phone: _____ Fax: _____

Step 6: Healthcare provider certification

By signing below, I confirm I have read and agree to the certification on page 6.

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

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

*National Provider Identifier.

It is the prescriber's responsibility to comply with any applicable state-specific prescription requirements, including electronic prescribing mandates and signature documentation requirements.

Step 6: 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 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 HIPAA to provide the personal 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 completed Start Form to PANTHERx Specialty Pharmacy. I understand the above-referenced patient's enrollment in Rhythm InTune is not a guarantee of coverage or access to IMCIVREE (including to patient or copay assistance) and that the purpose of this Support Service is to provide education, product support, and facilitate access to the patient. I understand that, if free product is provided, neither I nor the patient may seek reimbursement for any such product. I also understand that the patient is not eligible for copay assistance if he/she is enrolled in any federal healthcare program. If the patient requests 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 form.