Fax this completed page (page 1) to the pharmacy indicated in Section 1. Bolded fields with asterisks (*) are required.

Start Form

Phone: 1-844-789-8744
Hours of Operation: Monday-Friday, 8 AM to 8 PM ET

1 PREFERRED PHARMACY

Select ONE preferred pharmacy below.* You can choose to send the prescription to a digital pharmacy (BlinkRx) or specialty pharmacy (Accredo, CVS Specialty, Optum Specialty Pharmacy) in the network.

☐ **Accredo** Fax: 1-888-302-1028	☐ **BlinkRx** Fax: 1-866-585-4631	☐ **CVS Specialty** Fax: 1-800-323-2445	☐ **Optum Specialty Pharmacy** Fax: 1-877-342-4596

2 PATIENT INFORMATION

Patient First Name*: ____________ **Last Name*:** ____________ **DOB*:** ____________

Street Address*: ____________ **City*:** ____________ **State*:** ______ **ZIP Code*:** ______

Primary Phone #*,†(mobile preferred): ____________ Alternative #: ____________ Gender: ☐ Male ☐ Female

Email: ____________ Language: ☐ English ☐ Spanish ☐ Other ____________

Patient Representative/Care Partner Information (if applicable)

Representative/Care Partner Full Name: ____________ Relationship to Patient: ____________

Phone #: ____________ Email: ____________

†The patient's pharmacy will call or text this number to verify benefits and confirm shipment, so it is important they answer.

3 PRESCRIBER INFORMATION

Prescribing Provider Name*: ____________ Specialty: ____________ Practice Name: ____________

Office Contact Name: ____________ **Office Address*:** ____________

City*: ____________ **State*:** ______ **ZIP Code*:** ______ **Office Phone #*:** ____________

Office Fax #*: ____________ Email: ____________ **Prescribing Provider NPI #*:** ____________

4 DIAGNOSIS AND CLINICAL INFORMATION

Attach copies of triglyceride tests, acute pancreatitis history, past and current medications, and drug allergies.

ICD-10-CM Diagnosis Code*: ☐ E78.1 Pure hyperglyceridemia ☐ E78.2 Mixed hyperlipidemia ☐ E78.3 Hyperchylomicronemia ☐ E78.4 Other hyperlipidemia ☐ Other ____________

5 TRYNGOLZA PRESCRIPTION INFORMATION

Prescriber Instructions: Comply with state-specific requirements (eg, e-prescribing, state-specific prescription form, fax language). Either 1) fill out the information below and provide signature, OR 2) send an e-prescription to the preferred pharmacy indicated in Section 1.

Complete ONE of the sections below for the preferred dosage.*

Rx: TRYNGOLZA injection, 50 mg/0.8 mL single-dose autoinjector, NDC: 71860-102-01
☐ **50 mg** subcutaneously once monthly (Quantity=1)
Refills: ☐ 11 months or ☐ Other ____________

OR

Rx: TRYNGOLZA injection, 80 mg/0.8 mL single-dose autoinjector, NDC: 71860-101-01
☐ **80 mg** subcutaneously once monthly (Quantity=1)
Refills: ☐ 11 months or ☐ Other ____________

Quick Start: If eligible and when all information required for prior authorization is received, patient will be enrolled in the Quick Start program that will provide free drug during the insurance approval process. The Quick Start program is available to all insured patients. Eligibility is subject to the terms and conditions of the program. Ionis Pharmaceuticals® reserves the right to rescind, revoke, or amend the program at any time without notice.

By signing this form, I am indicating a prescribing decision has been made. In addition, I am certifying treatment with TRYNGOLZA indicated above is medically necessary for this patient, and I have received authorization to release the medical and/or other patient information relating to this therapy to Ionis Every Step™ and its affiliates, agents, and representatives to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I certify that, to the best of my knowledge, the patient and physician information in this form is complete, accurate, and consistent with applicable privacy regulations. For Quick Start: I understand that this medication is being provided free to the named patient by Ionis and agree that neither I nor the patient will bill an insurer or any government healthcare program for the cost of this medication. The program may not be combined with another offer and is not eligible to patients without insurance or whose insurer has made a final coverage determination.

☐ **Dispense as Written** **SIGN** ____________ ____________

Prescriber Signature *(Prescriber attests this is his/her legal signature. NO STAMPS)* Today's Date

ATTENTION: NY Providers, please also submit electronic prescriptions.

Tryngolza® (olezarsen) injection | IONIS EVERY STEP™ SUPPORT SERVICES

What to Expect After Your Doctor Prescribes TRYNGOLZA

The Ionis Every Step™ support program and your specialty pharmacy will work with your doctor to help you get started with treatment as quickly as possible

Get started today and stay supported with Ionis Every Step

1. **Your doctor sends the prescription to a specialty pharmacy.**

   You will need to keep an eye out for a phone call or text from the pharmacy.

2. **Answer your specialty pharmacy's phone call or text to review coverage and potential costs.**

   Together, you will review your **insurance coverage, out-of-pocket costs** for TRYNGOLZA, and potential **financial assistance options.**

3. **TRYNGOLZA is shipped directly to you.**

   The specialty pharmacy will confirm **delivery details** so they can send your prescription and a Welcome Kit; they will also give you injection training for your first dose.

4. **Your specialty pharmacy will reach out when it is time for a refill.**

   It is important to check that your refill will be shipped in time, or you can request it directly when your next dose is coming up.

Stay in touch with your specialty pharmacy

It is important to answer phone calls or texts from your specialty pharmacy so you can avoid delays in getting TRYNGOLZA. Scan the QR code for your pharmacy below, and make sure to save it in your phone as a contact.

Accredo
1-800-803-2523

BlinkRx
1-844-926-2480

CVS Specialty
1-800-237-2767

Optum Specialty Pharmacy
1-855-427-4682

Have questions about getting started on TRYNGOLZA?

If you need more support, or if you're not sure which pharmacy you are using, call the Ionis Every Step Support Center at **1-844-789-8744** (select option 2), Monday to Friday, 8 AM to 8 PM ET.

US-OLZ-2400009 v3.0 06/2026

Fax this completed page (page 3) to Ionis Every Step at 1-877-299-0015; please do not fax to pharmacy.
Bolded fields with asterisks (*) are required.

Start Form

Phone: 1-844-444-4351
Hours of Operation: Monday-Friday, 8 AM to 8 PM ET

Patient First Name*: ______________________ **Last Name*:** ______________________ **DOB*:** ____________

Street Address*: ______________________ **City*:** ______________ **State*:** ______ **ZIP Code*:** ____________

Primary Phone #*,†(mobile preferred): ______________________ Email: ______________________

PATIENT CONSENT AND SUPPORT PROGRAMS ENROLLMENT

Patient Authorization for the Use and Disclosure of Personal Information and Personal Health Information:
I authorize my healthcare provider(s) and staff, pharmacies, and health plans ("Providers") to share with and receive from Ionis Pharmaceuticals, Ionis Every Step™, and their personnel, service providers, and affiliates (altogether "Ionis") my personal information as described in this consent ("Consent"). My personal information includes contact, demographic, and financial information, as well as health insurance and benefit, and health information, such as prescription, medical condition and treatment information (commonly referred to as "Protected Health Information" or "PHI") (altogether "Information"). Uses of my Information include verifying treatment and payment decisions with my HCPs; investigating and assisting with coordination of coverage for Ionis medicines; coordinating prescription fulfillment and financial or affordability assistance, keeping Ionis and Providers informed about my prescription status, and participating in Ionis Every Step Patient Support Programs. I understand my Information may no longer be protected by state and federal law, but Ionis will only use my Information for these purposes and in accordance with applicable laws and the Ionis Privacy Policy (https://www.ionis.com/privacy-policy).

Ionis Every Step Patient Support Programs (the "Program") will receive and use my Information to determine if I qualify for the Program, to enroll me in the Program, to administer the Program, and to engage with me on Ionis' product(s) and topics of potential interest to me. Further, I understand Ionis may use my Information to inform my healthcare provider about my participation in the Program and to conduct occasional satisfaction surveys, data and marketing analytics, scientific research of non-identified data, and other internal business activities to better meet patient needs. For these purposes, Ionis may contact me by mail, email, fax, phone, voicemail, automated contact, and other mutually agreed upon means.

Voluntary Consent:
I understand that I do not have to sign this Consent to receive treatment with an Ionis product, payment for treatment, or insurance enrollment or benefits. However, if I do not sign, I understand I cannot receive Ionis Every Step Patient Support Programs. I understand that Providers may receive payment from Ionis for the Providers' services rendered in connection with this Consent. This Authorization expires ten (10) years from the date, unless a shorter period is required by law.

I understand that I have the right to cancel this Consent and obtain a copy of this authorization after I have signed it at any time by calling Ionis Every Step at 1-844-444-4351 or by submitting a written notice to: Ionis Every Step, P.O. Box 7613 Overland Park, KS 66207. After receiving my cancellation notice, the Providers and Ionis will discontinue sharing my Information with each other, but prior disclosures remain unaffected and my participation in Ionis Every Step Patient Support Programs will end.

Ionis Every Step Content SMS/Text Messaging Consent:
I expressly consent to receive text messages from or on behalf of Ionis Every Step Patient Support Programs at the mobile telephone number that I provide. I understand (1) message and data rates may apply, (2) I can opt out of text at any time by texting STOP to the number provided in any text message, and (3) I can get help for text messages by texting HELP. If Ionis Every Step updates its purposes or Privacy Policy, I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. The terms and conditions of Ionis Every Step communications are in this Consent and the Ionis Privacy Policy is on Page 1.

Ionis Marketing Communications Consent:
I authorize Ionis to contact me by mail, email, phone, fax, automated contact, and other mutually agreed upon means regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. Ionis will not sell or trade my Information to any unrelated third party. I understand I am not required to provide this consent as a condition of receiving any Ionis product or Patient Support Program and I can opt-out later.

Please check all required (*) boxes to qualify for Patient Support Programs including, but not limited to, financial assistance programs that may apply to you.

☐ **I consent to the Patient Authorization for the Use and Disclosure of Personal Information and Personal Health Information written above.***
☐ I consent to receiving text messages. Please see Ionis Every Step Content SMS/Text Messaging Consent written above.
☐ I consent to receiving other resources related to my medicine or disease using my information provided on this form. Please see Ionis Marketing Communications Consent written above.

By signing below, I certify that I have read and agree to the use of the Information in this Consent and participation in Patient Support Programs.

SIGN

______________________ ______________________ ____________
Patient/Authorized Representative Signature | Printed Patient/Authorized Representative Name (If applicable) | Today's Date

If signed by an authorized representative, please indicate below the authority to act on behalf of the patient:

☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions
☐ Other ______________________

©2026 Ionis Pharmaceuticals® and TRYNGOLZA® are registered trademarks, and Ionis Every Step™ is a trademark of Ionis Pharmaceuticals. All other trademarks are the property of their respective owners. All rights reserved. US-OLZ-2400009 v3.0 06/2026

IONIS