PRIOR AUTHORIZATION REQUEST

WAINUA

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If yes, skip to question 7.]		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Does the patient have confirmed Stage 1 or Stage 2 Familial Amyloid Polyneuropathy (FAP) or Coutinho Stage? ACTION required: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has diagnosis of hereditary transthyretin-mediated polyneuropathy been confirmed by documented genetic mutation in transthyretin (TTR) gene? ACTION required: submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient have signs and symptoms consistent with neuropathy associated with transthyretin amyloidosis and a Neuropathy Impairment Score (NIS) greater than or equal to 10 and less than or equal to 130? ACTION required: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Does the provider attest both male and female patients will use adequate contraception while receiving medication? [If no, no further questions.]	Yes	No
13	Does the provider attest other causes of neuropathy have been ruled out? [If no, no further questions.]	Yes	No
14	Does provider attest that the patient has not had a liver transplant, and is not a liver transplant candidate? [If no, no further questions.]	Yes	No
15	Does the provider attest that the patient will be prescribed vitamin A supplementation while receiving the requested medication?	Yes	No

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	[If no, no further questions.]		
16	Does the provider attest the requested medication will not be used in combination with vutrisiran (Amvuttra), patisiran (Onpattro), inoteresen (Tegsedi), tafamidis meglumine (Vyndaqel), tafamidis (Vyndamax), or acoramidis (Attruby)? [If no, no further questions.]	Yes	No
17	Is the requested drug being prescribed by or in consultation with a neurologist, geneticist, or physician with extensive knowledge in the treatment of amyloidosis? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed the Food and Drug Administration (FDA) labeled dosing? [Dosing: 45 mg SubQ once per month]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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