

# ATTR AMYLOIDOSIS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

**The following documentation is REQUIRED.** Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review  
 Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis <input type="checkbox"/> Polyneuropathy of hereditary transthyretin-mediated amyloidosis <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently being treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____ 3. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., cardiologist, geneticist, neurologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Has the patient received a liver transplant? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Will the patient be using the requested agent in combination with another agent targeted in this program (i.e., Attruby, Tegsedi, Vyndamax, Vyndaqel, Wainua), Onpattro, OR Amvuttra for the requested indication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is the patient’s age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide support for using the requested agent for the patient’s age for the requested indication: _____ _____ 7. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (such as contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max): _____ _____ _____ <b>For cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis:</b> 8. Has the diagnosis been confirmed by testing [e.g., stannous pyrophosphate (PYP) scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing (TTR genotyping)]? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Please submit medical records including chart notes and lab results</b> <b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<b>For cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis continued:</b> 9. Does the patient have clinical manifestations of cardiomyopathy (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>For polyneuropathy of hereditary transthyretin-mediated amyloidosis:</b> 10. Has the diagnosis been confirmed by testing (e.g., genetic testing, biopsy)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Please submit medical records including chart notes and lab results</b>			
11. Does the patient have clinical manifestations of polyneuropathy (e.g., neuropathic pain, altered sensation, numbness, tingling, impaired balance, motor disability)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>For renewal requests:</b> 12. Has the patient had clinical benefit with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 <b>TOLL FREE</b>		<b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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