PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 11/19/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?

   Cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) (If checked, go to 2) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

3. Is the requested drug being prescribed by or in consultation with a geneticist, cardiologist, or a physician specializing in the treatment of amyloidosis? **Y** ☐ **N** ☐

4. Does the patient exhibit clinical symptoms of heart failure (e.g., volume overload, dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) at baseline (prior to treatment with the requested drug)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation demonstrating the patient exhibits clinical symptoms of heart failure. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Does the patient have medical history of heart failure with at least one prior hospitalization for heart failure (not due to arrhythmia or conduction system disturbance treated with permanent pacemaker)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation of prior hospitalization of heart failure. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. Has the diagnosis been confirmed by the presence of transthyretin amyloid deposits on analysis of biopsy from cardiac or noncardiac sites? ACTION REQUIRED: If Yes, attach biopsy results showing the presence of transthyretin amyloid deposition. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Has the presence of transthyretin precursor proteins been confirmed by immunohistochemical analysis, mass spectrometry, tissue staining, or polarized light microscopy? ACTION REQUIRED: If Yes, attach immunohistochemical analysis, mass spectrometry, tissue staining, or polarized light microscopy results confirming transthyretin precursor proteins. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Has the presence of amyloid deposits been confirmed by technetium-labeled bone scintigraphy tracing? ACTION REQUIRED: If Yes, attach technetium-labeled bone scintigraphy tracing results confirming the presence of amyloid deposits. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Has systemic light chain amyloidosis been ruled out by showing the absence of monoclonal proteins by all of the following tests: A) serum kappa/lambda free light chain ratio, B) serum protein immunofixation, and C) urine protein immunofixation? ACTION REQUIRED: If Yes, attach serum kappa/lambda free light chain ratio, serum protein immunofixation, and urine protein immunofixation test results showing the absence of monoclonal proteins.
   ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

10. What is the patient's diagnosis?
   - Cardiomyopathy of variant transthyretin-mediated amyloidosis (If checked, go to 11) ☐
   - Cardiomyopathy of wild-type transthyretin-mediated amyloidosis (If checked, go to 12) ☐

11. Does the patient have a confirmed detection of a pathogenic or likely pathogenic variant in the transthyretin (TTR) gene? ACTION REQUIRED: If Yes, attach results confirming pathogenic or likely pathogenic variant in the TTR gene.
   ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

12. Is the patient a liver or heart transplant recipient? — **Y** ☐ **N** ☐

13. Does the patient have an implanted left-ventricular assist device (LVAD)? — **Y** ☐ **N** ☐

14. Will the requested drug be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra), eplontersen (Wainua), tafamidis meglumine (Vyndaqel), or tafamidis (Vyndamax)? — **Y** ☐ **N** ☐

15. Is this a request for continuation of therapy with the requested drug? — **Y** ☐ **N** ☐

16. Has the patient demonstrated a beneficial response to treatment with the requested drug (e.g., improvement in rate of disease progression as demonstrated by distance walked on the 6-minute walk test, the Kansas City Cardiomyopathy Questionnaire-Overall Summary [KCCQ-OS] score, cardiovascular-related hospitalizations, New York Heart Association [NYHA] classification of heart failure, left ventricular stroke volume, N-terminal B-type natriuretic peptide [NT-proBNP] level)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation confirming the patient demonstrates a beneficial response to treatment.
   ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date