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:** 1/30/2025
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 hereditary transthyretin-mediated amyloidosis (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Has the diagnosis been confirmed by positive 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

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

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

5. 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

6. What is the patient's diagnosis?
   - Cardiomyopathy of hereditary transthyretin-mediated amyloidosis (If checked, go to 7) ☐
   - Cardiomyopathy of wild-type transthyretin-mediated amyloidosis (If checked, go to 8) ☐

7. Does the patient have a confirmed transthyretin (TTR) gene mutation? ACTION REQUIRED: If Yes, attach results confirming a mutation of the transthyretin (TTR) gene. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Does the patient exhibit clinical symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation showing the patient exhibits clinical symptoms of cardiomyopathy and heart failure. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

9.	Is the patient a liver transplant recipient?	**Y** ☐	**N** ☐
10.	Will the requested medication be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra), or eplontersen (Wainua)?	**Y** ☐	**N** ☐
11.	Is this a request for continuation of therapy with the requested drug?	**Y** ☐	**N** ☐
12.	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, NYHA classification of heart failure, left ventricular stroke volume, N-terminal B-type natriuretic peptide [NT-proBNP] level)? ACTION REQUIRED: If Yes, attach medical record documentation confirming the member 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.

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Prescriber (Or Authorized) Signature and Date