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:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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?
   - Polyneuropathy of hereditary transthyretin-mediated amyloidosis (transthyretin-type familial amyloid polyneuropathy [ATTR-FAP]) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____

2. Was the diagnosis confirmed by detection of a mutation in the TTR gene? ACTION REQUIRED: If Yes, attach a copy of the testing or analysis confirming a mutation in the TTR gene.
   - Yes (If checked, go to 3) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

3. Does the patient exhibit clinical manifestations of ATTR-FAP (e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy)? ACTION REQUIRED: If Yes, attach medical record documentation confirming the patient demonstrates signs and symptoms of polyneuropathy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

4. Is the patient a liver transplant recipient? **Y** ☐ **N** ☐

5. Will the requested medication be used in combination with any other medication approved for the treatment of hereditary transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Tegsedi, Vyndaqel, Vyndamax)? **Y** ☐ **N** ☐

6. Will the requested medication be prescribed by or in consultation with any of the following: a) Neurologist, b) Geneticist, or c) Physician specializing in the treatment of amyloidosis? **Y** ☐ **N** ☐

7. Is the request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐

8. Has the patient demonstrated a beneficial response to treatment with the requested medication compared to baseline (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation supporting clinical benefit of therapy compared to baseline. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

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

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