BlueCross BlueShield
Federal Employee Program

ATTRUBY
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Attruby

(acoramidis)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 336 tablets every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets every 84 days

2. Does the patient have a diagnosis of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) cardiomyopathy? ❑Yes ❑No

3. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Has the diagnosis been confirmed by a genetic test **OR** tissue biopsy showing amyloid deposition? ❑Yes ❑No
   b. Does the patient have an end-diastolic interventricular septal wall thickness greater than or equal to 12 millimeters by echocardiography? ❑Yes ❑No
   c. Does the patient have a history of heart failure with at least one hospitalization for heart failure **OR** clinical evidence of heart failure with signs and symptoms of volume overload or elevated intracardiac pressures requiring treatment with a diuretic for improvement? ❑Yes ❑No
   d. Does the patient have a baseline NT-proBNP greater than or equal to 300 picograms per milliliter (pg/mL)? ❑Yes ❑No
   e. Is the patient experiencing NYHA class I through class III symptoms due to ATTR cardiomyopathy? ❑Yes ❑No
   f. Does the patient have light-chain amyloidosis? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient's condition improved or stabilized with therapy [e.g., reduced number of hospitalizations, improved 6-minute walk test (6-MWT), or improved Kansas City Cardiomyopathy Questionnaire Overall Summary Score (KCCQ-OS)]? ❑Yes ❑No