BlueCross BlueShield
Federal Employee Program

TEGSEDI
PRIOR APPROVAL REQUEST

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.

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

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					

Tegsedi (inotersen)

****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

How many syringes will the patient need for an 84 day supply? _____ syringe(s) per 84 days

1. What is the patient's diagnosis?
   - ❑ Polyneuropathy of Hereditary Transthyretin-mediated (hATTR) amyloidosis
   - ❑ Other diagnosis ***(please specify)***: _____
2. Does the patient have a platelet count of greater than or equal to 100,000 cells per microliter? ❑Yes ❑No
3. Does the patient have an eGFR greater than or equal to 45 mL/min/1.73m^2? ❑Yes ❑No
4. Does the prescriber agree to monitor platelet count, renal function (serum creatinine, eGFR, and urinalysis), and liver function (ALT, AST, and total bilirubin) during therapy with Tegsedi? ❑Yes ❑No
5. Does the prescriber agree to supplement the patient with the recommended daily allowance of Vitamin A if indicated? ❑Yes ❑No
6. Are both the prescriber and patient enrolled in the Tegsedi REMS program? ❑Yes ❑No
7. Will Tegsedi be used in combination with another *****Prior Authorization (PA) medication for polyneuropathy caused by hATTR amyloidosis? ❑Yes***** ❑No

   ****If YES***, please specify medication: _____

   ****PA Medications: Amvuttra (vutrisiran), Onpattro (patisiran)***
8. Has the patient been on Tegsedi 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 patient's diagnosis been confirmed by genetic testing or tissue biopsy showing amyloid deposition? ❑Yes ❑No
   - b. Does the patient have a baseline score using the polyneuropathy disability (PND) scoring tool less than or equal to Stage IIIb? ❑Yes ❑No*****

     ****If NO***, does the patient have a baseline score of Stage 1 or 2 using the FAP scoring tool? ❑Yes ❑No
   - c. Does the patient have New York Heart Association (NYHA) class 3 or 4 heat failure? ❑Yes ❑No
   - d. Does the patient have a sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)? ❑Yes ❑No
   - e. Has the patient had a prior liver transplantation? ❑Yes ❑No
   - f. Is Tegsedi being prescribed by or in consultation with a neurologist, or a specialist in the treatment of the patient's diagnosis? ❑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 Tegsedi? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***