BlueCross BlueShield
Federal Employee Program

WAINUA
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					

Wainua (eplontersen)

****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 3 single-dose autoinjectors every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ single-dose autoinjectors every 90 days

2. Does the patient have a diagnosis of polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis? ❑Yes ❑No

3. Does the prescriber agree to supplement the patient with the recommended daily allowance of Vitamin A if indicated? ❑Yes ❑No

4. Will this medication 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), Tegsedi (inotersen)

5. 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 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 heart 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 Wainua 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 therapy? ❑Yes ❑No