Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Vyndamax-Vyndaqel
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender: ☐ Male	☐ Female	Height:
Member ID:	City:	State:		Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Requested Medication:	☐ **Vyndamax**	☐ **Vyndaqel**	☐ **Other, please specify:** ____________
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	ICD-10 Code:	Diagnosis:	
What medication(s) have been tried and failed for diagnosis?			
Are there any contraindications to formulary medications? If yes, please specify:		☐ Yes	☐ No
Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: ____________

Clinical Information		
Has documentation of confirmed ATTR-CM diagnosis been provided?	☐ Yes	☐ No
Is there attestation of negative history of New York Heart Association (NYHA) Class III heart failure?	☐ Yes	☐ No
Is there genetic testing to confirm wild type OR hereditary transthyretin-mediated amyloidosis (ATTR-CM)?	☐ Yes	☐ No
Is there medical history of heart failure that includes one of the following: at least 1 prior hospitalization of heart failure OR clinical evidence of heart failure?	☐ Yes	☐ No
Is there evidence of cardiac involvement on an echo with increased wall thickness?	☐ Yes	☐ No
Is there previous hypersensitivity to tafamidis or tafamidis meglumine?	☐ Yes	☐ No
Is the member currently taking Onpattro OR Tegsedi?	☐ Yes	☐ No
☐ Renewal Request ONLY		
Has documentation of clinical benefit through improvement of symptoms been submitted with this request?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records		

Signature affirms that information given on this form is true and accurate and reflects office notes.	
Prescribing Provider's Signature: ____	**Date:** ________________

<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 866-316-3784 to check the status of a request.

Proprietary