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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATIONS ATTRUBY™ (acoramidis), VYNDAQEL® (tafamidis meglumine) and VYNDAMAX™ (tafamidis)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 1-year approval:

1. Is the prescriber a cardiologist or in consultation with a cardiologist?
   ☐ Yes ☐ No
2. Is the member 18 years of age or older?
   ☐ Yes ☐ No
3. Does the member have a diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM), including wild-type transthyretin amyloidosis (ATTRwt) or hereditary transthyretin amyloidosis (hATTR), confirmed by one of the following:
   a. Bone scintigraphy
   b. Endomyocardial biopsy
   c. For patients with hATTR, genetic testing

   ☐ Yes ☐ No
4. Has the diagnosis of light chain (AL) amyloidosis CM been ruled out through testing for the presence of light chains?
   ☐ Yes ☐ No
5. Does the member have a history of heart failure (HF), as evidenced by at least one prior hospitalization or current clinical manifestations?
   ☐ Yes ☐ No
6. Does the member have New York Heart Association (NYHA) Class IV HF at the time of initial request?
   ☐ Yes ☐ No
7. Is the drug being prescribed in combination with another transthyretin (TTR)-targeted agent?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For renewal, complete the following questions to receive a 1-year approval:

8. Does the member continue to meet the above criteria (questions 1 through 7)?
   ☐ Yes ☐ No
9. Does the member continue to experience clinical benefit from the requested treatment?
   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.