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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATIONS 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: _____

Gender: ☐ **Male** ☐ **Female**

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 6-month approval:

1. Is the member 18 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the member have a definitive diagnosis of amyloid transthyretin (ATTR) amyloidosis as documented by amyloid deposition on tissue biopsy, scintigraphy, or genetic testing? **AND**

   ☐ Yes ☐ No

3. Does the member have evidence of cardiac involvement as documented by echocardiography (ECG) with an end-diastolic interventricular septal wall thickness > 12 mm? **AND**

   ☐ Yes ☐ No

   a. Does the member have a history of heart failure (HF) which required ≥ 1 hospitalization? **OR**

      ☐ Yes ☐ No

   b. Does the member have clinical evidence of HF, without a prior history of hospitalization for disease, manifested by signs or symptoms of volume overload or elevated cardiac pressure (e.g., elevated jugular venous pressure, shortness of breath or signs of pulmonary congestion on x-ray or auscultation, peripheral edema) which requires/required treatment with a diuretic? **AND**

      ☐ Yes ☐ No

4. Is there confirmation that the member does NOT have any of the following:

   a. New York Heart Association (NYHA) classification of IV; **AND**
   b. Primary (light chain) amyloidosis; **AND**
   c. Prior liver transplant; **AND**
   d. Implanted cardiac mechanical-assist device (left-ventricular assist device)? **AND**

   ☐ Yes ☐ No

5. Is there confirmation that tafamidis is NOT being used in combination with other transthyretin (TTR) reducing agents (e.g., inotersen, patisiran, etc.)?

   ☐ 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:

6. Does the member continue to meet the above criteria? **AND**
   ☐ Yes ☐ No
7. Does the member demonstrate absence of unacceptable toxicity from the drug? **AND**
   ☐ Yes ☐ No
8. Does the member demonstrate disease response compared to pre-treatment baseline as evidenced by a decreased frequency of cardiovascular-related hospitalizations?
   ☐ 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.