Wellpoint

Transthyretin Agents

Contains confidential patient information
Complete form in its entirety and fax to Prior Authorization of Benefits Center at **844-474-3341**.

1. Patient Information	**2. Physician Information**
Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**

7. Diagnosis _____

8. Approval criteria: Item (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

☐ Yes ☐ No Does the patient have a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in the last 730 days?
☐ Yes ☐ No Does the cardiac/non-cardiac tissue biopsy confirm the presence of amyloid deposits?
☐ Yes ☐ No Has the diagnosis been documented by confirmation of TTR precursor protein (wild

type ATTR-CM) or confirmation of a TTR gene mutation (hereditary ATTR-CM)?
☐ Yes ☐ No Does the client have a diagnosis of New York Heart Association (NYHA) Functional Class (FC) IV heart failure?
☐ Yes ☐ No Does the patient have a history of heart or liver transplant in the last 365 days?
☐ Yes ☐ No Will the patient have concurrent therapy with inotersen or patisiran?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at https://www.txvendordrug.com/formulary/formulary-search

9. Physician signature

_____	_____
Prescriber or authorized signature	*Date*

PA of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.