Tegsedi

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Polyneuropathy of hereditary transthyretin-mediated amyloidosis ❑ Other _____
2. What is the ICD-10 code? _____
3. Was the diagnosis confirmed by detection of a mutation in the TTR gene? ***ACTION REQUIRED: If Yes, attach a copy of the TTR gene test result.*** ❑ Yes ❑ No ❑ Unknown
4. Does the patient exhibit clinical manifestations of polyneuropathy of hereditary transthyretin-mediated amyloidosis (ATTR-FAP) (e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy)? ***ACTION REQUIRED: If Yes, attach medical record documentation confirming clinical manifestations of the condition.*** ❑ Yes ❑ No
5. Is the patient a liver transplant recipient? ❑ Yes ❑ No
6. Will the requested medication be used in combination with either patisiran (Onpattro) or tafamidis (Vyndaqel, Vyndamax)? ❑ Yes ❑ No
7. Is the requested medication prescribed by or in consultation with any of the following: a) neurologist, b) geneticist, or c) physician specializing in the treatment of amyloidosis? ❑ Yes ❑ No
8. Is the request for a continuation of therapy with Tegsedi? ❑ Yes ❑ No *If No, no further questions.*
9. Has the patient demonstrated a beneficial response to Tegsedi therapy compared to baseline (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength). ***ACTION REQUIRED: If Yes, attach medical record documentation confirming improvement of the condition.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155