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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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. The preferred product for your patient's health plan is Onpattro. Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No *If No, skip to #7*
6. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Onpattro)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
7. 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
8. 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
9. Is the patient a liver transplant recipient? ❑ Yes ❑ No
10. Will the requested medication be used in combination with either patisiran (Onpattro) or tafamidis (Vyndaqel, Vyndamax)? ❑ Yes ❑ No
11. 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
12. Is the request for a continuation of therapy with Tegsedi? ❑ Yes ❑ No *If No, no further questions.*

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

13. 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)**

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