2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	**Phone** (10-15 **minutes** process time)	**Fax** (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Amvuttra

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Amvuttra MR SOC SGM 3025-D, 5491-A– 07/2023.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Exception Criteria Questions:

A. Is the product being requested for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis? ❑ Yes ❑No *If No, skip to Site of Service Questions*

B. The preferred product for your patient's health plan is Onpattro.
Can the patient's treatment be switched to a preferred product?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ No

C. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No, *If No, skip to Question E*

D. 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 Site of Service Questions*

E. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Onpattro)? ***ACTION REQUIRED: If 'Yes', please attach supporting chart note(s).***
❑ Yes ❑ No

Site of Service Questions:

A. Where will this drug be administered?
❑ Ambulatory surgical, *skip to Clinical Questions*
❑ Home infusion, *skip to Clinical Questions*
❑ Off-campus Outpatient Hospital
❑ On-campus Outpatient Hospital
❑ Physician office, *skip to Clinical Questions*
❑ Pharmacy, *skip to Clinical Questions*

B. Is this request to continue previously established treatment with the requested medication?
❑ Yes - This is a continuation of an existing treatment.
❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months). *If No, skip to Clinical Criteria Questions*

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, Attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.*** ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the diagnosis?
❑ Polyneuropathy of hereditary transthyretin-mediated amyloidosis (transthyretin-type familial amyloid polyneuropathy (ATTR-FAP))
❑ Other _____

2. What is the ICD-10 code? _____

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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 inotersen (Tegsedi), patisiran (Onpattro) or tafamidis (Vyndaqel, Vyndamax)? ❑ Yes ❑ No

7. Is the requested medication prescribed by or in consultation with any of the following:
   - ❑ Neurologist
   - ❑ Geneticist
   - ❑ Physician specializing in the treatment of amyloidosis
   - ❑ None of the above

8. Is the request for a continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, no further questions.*

9. Has the patient demonstrated a beneficial response to the requested drug 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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