Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
VYNDAQEL (Tafamidis Meglumine) VYNDAMAX (Tafamidis) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **VYNDAQEL (Tafamidis Meglumine) VYNDAMAX (Tafamidis).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Cardiologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the Member's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the member ≥18 years of age?
   □ No □ Yes

2. AND does the member have a diagnosis of cardiac amyloidosis or per cardiologist documentation?
   □ No □ Yes

3. AND have evidence of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) demonstrated by positive biopsy demonstrating transthyretin (TTR)-amyloid deposition OR meeting all 3 of the following:
   a. Diagnosis of heart failure (defined as stage C heart failure plus NYHA Class I, II, or III);
   b. Pyrophosphate (PYP) scintigraphy cardiac uptake visual score of either grade 2 or 3 using Perugini Grade 1-3 scoring system, calculated heart-to-contralateral (H/CL) ration ≥1.5;
   c. Absence of monoclonal gammopathy after testing for serum immunofixation (IFE) and serum free light chains
   □ No □ Yes

4. AND does the member have a medical history of heart failure with at least 1 prior hospitalization for heart failure or clinical evidence of heart failure (without hospitalization) manifested by signs or symptoms of volume overload or elevated intracardiac pressures that require treatment diuretic**?**
   □ No □ Yes

5. AND member is NOT receiving inotersen or patisiran?
   □ No □ Yes

6. AND member has NOT had prior heart or liver transplantation?
   □ No □ Yes

7. AND member does NOT have an implanted cardiac mechanical assist device?
   □ No □ Yes

For Continuation of Therapy, Please Respond to <u>Additional Questions</u> Below:

1. Does the member have documentation of positive clinical response?
   □ No □ Yes

2. AND has the member had an office visit or telephone visit with a specialist within the past 12 months?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**