



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  $\geq 18$  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) ratio  $\geq 1.5$ ;
  - 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 Additional Questions 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:**

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

**Prescriber Signature:**

**Date:**

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