US Family Health Plan

Prior Authorization Request Form for

Acoramidis HCL (Attruby)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being prescribed by or in consultation with a specialist who manages hereditary transthyretin amyloidosis (for example, cardiologist, geneticist, or neurologist)?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age OR older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of wild type or hereditary transthyretin-mediated amyloidosis?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[13 December 2024]