# USFHP Prior Authorization Request Form for **tafamidis meglumine (Vyndaqel), tafamidis (Vyndamax)**

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**

**https://www.usfamilyhealth.org/for-providers/pharmacy-information/**

**Prior authorization does not expire. Clinical documentation may ne required.**

**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 patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Does the patient have a diagnosis of wild type or hereditary transthyretin-mediated amyloidosis?** | ☐ Wild type or hereditary transthyretin-mediated amyloidosis - Proceed to question **3**<br>☐ ATTR-polyneuropathy - **STOP - Coverage not approved**<br>☐ Other diagnosis – **STOP - Coverage not approved** | |
| **3. 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<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Is the patient receiving concurrent treatment with acoramidis (Attruby), Tegsedi (inotersen), Onpattro (patisiran), Amvuttra (vutrisiran) or eplontersen (Wainua)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |

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

Prescriber Signature _____ Date _____

[15 July 2026]