US Family Health Plan

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**

Medical documentation may be required. Failure to provide could result in denial.
Prior authorization does not expire.

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 GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of wild type or hereditary transthyretin-mediated amyloidosis?	☐ Yes Proceed to question **3**	☐ No **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 Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient female with childbearing potential?	☐ Yes Proceed to question **5**	☐ No **Sign and date below**
5. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Is the patient breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Will the patient take highly effective contraception during treatment and for 1 month after the last dose?	☐ 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 _____

[29 January 2020]