US Family Health Plan

Prior Authorization Request Form for

Eplontersen (Wainua)

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**

Initial prior authorization expires after 1 year, renewal criteria is approved indefinitely. For renewal of therapy an initial prior authorization approval is 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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Wainua.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient demonstrated improvement in neuropathy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a specialist who manages hereditary transthyretin amyloidosis (hATTR), such as a neurologist, cardiologist, and/or medical geneticist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have documented evidence of hATTR polyneuropathy as confirmed by genetically confirmed transthyretin mutation resulting in Coutinho stage 1 or 2 hereditary transthyretin-mediated amyloidosis (hATTR)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have documented evidence of hATTR polyneuropathy as confirmed by polyneuropathy secondary to hereditary transthyretin-mediated amyloidosis?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Does the patient have documented evidence of hATTR polyneuropathy as confirmed by a Neuropathy Impairment Score between 10-130?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving concurrent treatment with Tegsedi (inotersen), Onpattro (patisiran), Amvuttra (vutrisiran) or Vyndaqel/Vyndamax (tafamidis)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the provider acknowledge that the patient will receive an oral Vitamin A supplement at the recommended daily allowance while receiving the requested medication?	☐ 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 _____