SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Wainua™ (eplontersen)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: 45 mg administered by subcutaneous injection once monthly

Quantity Limit: 1 injection (0.8 mL) per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Medication is prescribed by or in consultation with a specialist in the area of the member's diagnosis
- ❑ Member is 18 years of age or older
- ❑ Member has a confirmed diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis confirmed by testing (e.g., genetic testing, biopsy)
- ❑ Member has clinical manifestations of polyneuropathy (e.g., neuropathic pain, altered sensation, numbness, tingling, impaired balance, motor disability)

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- ❑ Member will avoid using this in combination with other transthyretin reducing or stabilizing agents (e.g., acoramidis, inotersen, tafamidis, patisiran, or vutrisiran)
- ❑ Prescriber will supplement vitamin A at the recommended daily allowance as appropriate and refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness, dry eyes) occur
- ❑ Member has not received a liver transplant

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member continues to meet the relevant criteria identified in the initial criteria
- ❑ Member continues to experience clinical benefit from the requested treatment
- ❑ Member has an absence of unacceptable toxicity from the drug

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~3/21/2024;~~ 5/28/2026
REVISED/UPDATED/REFORMATTED: ~~4/26/2024; 6/15/2026~~, 8/11/2026