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.**

Transthyretin Stabilizers

Drug Requested:

❑ **Attruby™** (acoramidis)	❑ **Vyndamax™** (tafamidis)	❑ **Vyndaqel®** (tafamidis meglumine)

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 Dosing & Quantity Limits:

Drug Name	Dosing	Quantity Limits
Attruby™ (acoramidis)	712 mg twice daily	4 tablets per day
Vyndamax™ (tafamidis)	61 mg once daily	1 capsule per day
Vyndaqel® (tafamidis meglumine)	80 mg once daily	4 capsules per day

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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

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a cardiologist
- ❑ Light chain amyloidosis CM has been ruled out through testing for the presence of light chains
- ❑ Member has a history of heart failure (HF) as evidenced by at least one prior hospitalization or current clinical manifestations
- ❑ Member has New York Heart Association (NYHA) class IV HF at the time of initial request **(submit chart notes)**
- ❑ Member has a diagnosis of wild type or hereditary (variant) transthyretin amyloid cardiomyopathy (ATTR-CM) confirmed by **ONE** of the following **(submit documentation)**:
  - ❑ Cardiac tissue biopsy demonstrating histologic confirmation of transthyretin (TTR) amyloid deposits
  - ❑ Nuclear scintigraphy imaging (e.g., with Tc-PYP) showing grade 2 or 3 cardiac uptake
  - ❑ Genetic testing confirming a pathogenic transthyretin mutation (i.e.,Val122Ile)
- ❑ Requested medication will **NOT** be used in combination with another therapy targeting transthyretin (e.g., Attruby™, Vyndamax™, Vyndaqel®, Amvuttra™, Onpattro®, Wainua™)

Reauthorization: 12 months. 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.

- ❑ Member continues to meet the above criteria
- ❑ Member continues to experience clinical benefit from the requested treatment

Medication being provided by Specialty Pharmacy - PropriumRx

*****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:** ~~9/20/2019;~~ **1/23/2025**
REVISED/REFORMATTED/UPDATED: ~~10/8/2019; 12/7/2020; 10/27/2023; 3/15/2024;2/18/2025;~~ **7/1/2026**