Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Transthyretin-Mediated Amyloidosis (ATTR) Products – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

General Questions:

1. What is the diagnosis? _____
2. Is the medication being prescribed by or in consultation with a neurologist, cardiologist, or a specialist in the treatment of ATTR? □ **Yes** □ **No**
3. Does the member have clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, motor disability, cardiovascular dysfunction, carpal tunnel syndrome, etc.)? □ **Yes** □ **No**
4. What other drugs will the member be receiving with the requested drug?
   _____
5. What is the member's current weight? _____ pounds
   _____ kilograms
6. What is the member's current height? _____ feet _____ inches
   _____centimeters
7. Is there documentation of diagnosis confirmed by genotyping, biopsy, immunohistochemical analysis, scintigraphy, or mass spectrometry? □ **Yes** □ **No**
8. Please answer the questions below associated with the drug being requested.

Medicaton	**Question(s)**
Patisiran (**Onpattro**®)	Does the member have a diagnosis of polyneuropathy of hereditary transthyretin-mediated Amyloidosis? □ **Yes** □ **No**
Tafamidis meglumine (**Vyndaqel**®, **Vyndamax**®)	Is the medication is being used to treat cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) to reduce cardiovascular mortality and cardiovascular-related hospitalization? □ **Yes** □ **No**
Inotersen (**Tegsedi**®)	1. Does the member have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis? □ **Yes** □ **No** 2. Does the member have any of the following contraindications: i. Patient has platelet count < 100,000/mm3 □ **Yes** □ **No** ii. History of acute glomerulonephritis caused by Tegsedi □ **Yes** □ **No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Transthyretin-Mediated Amyloidosis (ATTR) Products – Medical Necessity Request

****Complete page 2 only for Subsequent/Renewal requests****

1. What is the diagnosis? _____

2. What is the member's current weight? _____ pounds
_____ kilograms

3. What is the member's current height? _____ feet _____ inches
_____centimeters

4. Is there documentation that the member has experienced a positive clinical response to medication (e.g., improved neurologic impairment, motor function, quality of life, etc.)? □ **Yes** □ **No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**