Tegsedi (inotersen)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Hereditary Transthyretin Amyloidosis (hATTR) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Initial Request:

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is the patient wheelchair-bound? ☐ **Yes** ☐ **No**

- **Please provide Copy of pathology report showing: (a) amyloid deposition in biopsy specimen(s), and (b) presence of amyloid precursor protein;**

AND

- **Please provide Copy of TTR gene analysis performed in parallel with tissue biopsy documenting the presence of disease-causing mutation(s) in the TTR gene**

Is the medication being prescribed by or in consultation with a neurologist, geneticist, or physician specializing in the treatment of amyloidosis? ☐ **Yes** ☐ **No**

Has the patient received a liver transplant? ☐ **Yes** ☐ **No**

Does the patient have moderate or severe hepatic impairment? ☐ **Yes** ☐ **No**

Will Tegsedi (inotersen) be used in combination with patisiran (Onpattro), tafamidis (Vyndaqel, Vyndamax) or vutrisiran (Amvuttra)? ☐ **Yes** ☐ **No**

Does the patient have New York Heart Association (NYHA) class III or IV functional class? ☐ **Yes** ☐ **No**

Does the patient have sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)? ☐ **Yes** ☐ **No**

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Has the patient previously been treated with with Wainua (eplontersen) or Onpattro (patisiran), or other oligonucleotide or RNA therapeutic (including siRNA)? ☐ **Yes** ☐ **No**

Renewal Request:

Has the patient demonstrated significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improved ambulation, improvement in neurologic symptom burden, improvement in activities of daily living) (documentation required)? ☐ **Yes** ☐ **No**

Will Tegsedi (inotersen) be used in combination with Wainua(eplontersen), patisiran (Onpattro), tafamidis (Vyndaqel, Vyndamax) or vutrisiran (Amvuttra)? ☐ **Yes** ☐ **No**

Does the patient have moderate or severe hepatic impairment? ☐ **Yes** ☐ **No**

Does the patient have New York Heart Association (NYHA) class III or IV functional class? ☐ **Yes** ☐ **No**

Does the patient have sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)? ☐ **Yes** ☐ **No**

Has the patient previously been treated with with Wainua (eplontersen) or Onpattro (patisiran), or other oligonucleotide or RNA therapeutic (including siRNA)? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Prime Therapeutics Management – Commercial Clients. Revision Date: 11.1.24
CAT009

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909