Attruby (acoramidis)
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:**
☐ Transthyretin amyloid cardiomyopathy(wild-type or hereditary) ☐ Other diagnosis: _____ ICD-10 Code(s):	

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

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

Is patient currently taking Vyndamax or Vyndaqel(tafamidis)? ☐ **Yes** ☐ **No**

If Yes to the above question, will the Vyndamax/Vyndaqel(tafamidis) be discontinued when Attruby(acoramdis) is started? ☐ **Yes** ☐ **No**

Is patient currently taking Amvuttra(vutrisiran)? ☐ **Yes** ☐ **No**

If Yes to the above question, will the Amvuttra(vutrisiran) be discontinued when Attruby(acoramdis) is started? ☐ **Yes** ☐ **No**

Does patient have a history of heart failure with at least one prior hospitalization for heart failure? □ **Yes** □ **No**

Does patient have clinical evidence of heart failure without hospitalization(defined as signs and symptoms of volume overload or elevated intracardiac pressures requiring treatment with a diuretic)? □ **Yes** □ **No**

Is patient's echocardiogram consistent with or suggestive of amyloidosis? □ **Yes** □ **No** ***Please submit echocardiogram report.***

Does patient have evidence of a left ventricular wall (interventricular septum or left ventricular posterior wall) thickness ≥12 mm? □ **Yes** □ **No** ***Please submit documentation.***

Does patient have an N-terminal pro-B-type natriuretic peptide(NT-proBNP) level greater than or equal to 600pg/mL? □ **Yes** □ **No** ***Please submit lab report.***

Does patient have a B-type natriuretic peptide(BNP) level greater than or equal to 100pg/ml? □ **Yes** □ **No** ***Please submit lab report.***

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If patient had used Vyndamax/Vyndaqel(tafamidis) prior to requesting Attruby(acoramidis), was initial pre- Vyndamax/Vyndaqel NT-proBNP was greater than or equal to 300 pg/mL ? □ **Yes** □ **No** ***Please submit lab report.***

Does patient have a New York Heart Association(NYHA) class I, II or III disease? □ **Yes** □ **No**

Does patient have a confirmed transthyretin precursor protein present via a Grade 2 or Grade 3 positive Tc-pyrophosphate(PYP) scan? □ **Yes** □ **No** ***Please submit imaging report.***

Are patient's serum immunofixation results within normal range? □ **Yes** □ **No** ***Please submit lab report.***
Are patient's serum immunofixation results above the upper range of normal listed on the lab report? □ **Yes** □ **No** ***Please submit lab report.***

Are patient's urine immunofixation results within normal range? □ **Yes** □ **No** ***Please submit lab report.***
Are patient's urine immunofixation results above the upper range of normal listed on the lab report? □ **Yes** □ **No** ***Please submit lab report.***

Are patient's serum electrophoresis/free light-chain assay results within normal range? □ **Yes** □ **No** ***Please submit lab report.***
Are patient's serum electrophoresis/free light-chain assay results above the upper range of normal listed on the lab report? □ **Yes** □ **No** ***Please submit lab report.***

Is patient's free light-chain level within normal range? □ **Yes** □ **No** ***Please submit lab report.***
Is patient's free light-chain level above the upper range of normal on the lab report? □ **Yes** □ **No** ***Please submit lab report.***

Does patient have a confirmed transthyretin precursor protein present via a Grade 1 positive Tc-pyrophosphate(PYP) scan? □ **Yes** □ **No** ***Please submit imaging report.***

Is patient's ATTR amyloid histologically confirmed and typed from an endomyocardial tissue biopsy specimen?
□ **Yes** □ **No** ***Please submit tissue biopsy.***

Is patient's ATTR amyloid histologically confirmed and typed from ANY tissue biopsy specimen? □ **Yes** □ **No**
Please submit tissue biopsy.

Does a hematology consultation report rule out light-chain disease? □ **Yes** □ **No** ***Please submit report.***

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

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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:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909