

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 ( <b>Onpatro</b> ®), Vutrisiran ( <b>Amyvuttra</b> ®)	Does the member have a diagnosis of polyneuropathy of hereditary transthyretin-mediated Amyloidosis? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Tafamidis meglumine ( <b>Vyndagel</b> ®, <b>Vyndamax</b> ®)	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? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Inotersen ( <b>Tegsedi</b> ®)	1. Does the member have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  2. Does the member have any of the following contraindications: i. Patient has platelet count < 100,000/mm <sup>3</sup> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> ii. History of acute glomerulonephritis caused by Tegsedi <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

Physician office's signature\* \_\_\_\_\_ Print Name \_\_\_\_\_

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

**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