



# Vyndamax (tafamidis) Prior Authorization Request Form



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

**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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI\\_DISCLOSURE\\_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY		<input type="checkbox"/> RENEWAL	
DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THERAPY INITIATED:	

*Continued on next page*





# Vyndamax (tafamidis) Prior Authorization Request Form



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

MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b>		<b>ICD-10:</b>
<input type="checkbox"/> Transthyretin amyloid cardiomyopathy (wild-type or hereditary) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b> <b>Does patient have an end-diastolic interventricular septal wall thickness exceeding 12mm?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit echocardiogram report <u>with above measurement CIRCLED on the report.</u></i>  <b>Does patient have a history of heart failure with at least one prior hospitalization for heart failure?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>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)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Is patient's echocardiogram consistent with or suggestive of amyloidosis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit echocardiogram report.</i>  <b>Does patient have an N-terminal pro-B-type natriuretic peptide (NT-proBNP) level greater than or equal to 600pg/mL?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i>  <b>Does patient have a B-type natriuretic peptide (BNP) level greater than or equal to 500pg/ml?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i>  <b>Does patient have a New York Heart Association (NYHA) class I, II or III disease?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Does patient have a confirmed transthyretin precursor protein present via a Grade 2 or Grade 3 positive Tc-pyrophosphate (PYP) scan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit imaging report.</i>  <b>Are patient's serum immunofixation results within normal range?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i> <b>Are patient's serum immunofixation results above the upper range of normal listed on the lab report?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i>  <b>Are patient's urine immunofixation results within normal range?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i> <b>Are patient's urine immunofixation results above the upper range of normal listed on the lab report?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i>  <b>Are patient's serum electrophoresis/free light-chain assay results within normal range?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab report.</i>		





**Vyndamax (tafamidis)**  
**Prior Authorization Request Form**



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

MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

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?

**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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

