TRICARE Prior Authorization Request Form for
eplontersen (Wainua)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial prior authorization expires after 1 year, renewal criteria is approved indefinitely. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Wainua.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient demonstrated improvement in neuropathy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a specialist who manages hereditary transthyretin amyloidosis (hATTR), such as a neurologist, cardiologist, and/or medical geneticist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have documented evidence of hATTR polyneuropathy as confirmed by genetically confirmed transthyretin mutation resulting in Coutinho stage 1 or 2 hereditary transthyretin-mediated amyloidosis (hATTR)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have documented evidence of hATTR polyneuropathy as confirmed by polyneuropathy secondary to hereditary transthyretin-mediated amyloidosis?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Does the patient have documented evidence of hATTR polyneuropathy as confirmed by a Neuropathy Impairment Score between 10-130?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving concurrent treatment with Tegsedi (inotersen), Onpattro (patisiran), Amvuttra (vutrisiran) or Vyndaqel/Vyndamax (tafamidis)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the provider acknowledge that the patient will receive an oral Vitamin A supplement at the recommended daily allowance while receiving the requested medication?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 August 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: