FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Vyndamax™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Vyndamax prescribed by or in consultation with a cardiologist? ❑ **Yes** ❑ **No**

Clinical Information:

Does the patient have a transthyretin (TTR) mutation (e.g., V1SSI)? ❑ **Yes** ❑ **No**

Does the patient have cardiac or noncardiac tissue biopsy demonstrating confirmation of TTR amyloid deposits? ❑ **Yes** ❑ **No**

Select if the patient has the following:

- ❑ Echocardiogram or cardiac magnetic resonance image suggestive of amyloidosis
- ❑ Scintigraphy scan suggestive of cardiac TTR amyloidosis
- ❑ Absence of light-chain amyloidosis

Does the patient have a history of heart failure (HF), with at least one prior hospitalization for HF? ❑ **Yes** ❑ **No**

Does the patient have clinical signs and symptoms of HF (e.g., dyspnea, edema)? ❑ **Yes** ❑ **No**

Does the patient have New York Heart Association (NYHA) Functional Class I, II, or III heart failure? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Does the patient continue to have NYHA Functional Class I, II, or III heart failure? ❑ **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: This request may be denied unless all required information is received.

Office use only: Vyndamax_FS_2019Sep-W