



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Tegsedi (inotersen)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://www.providers.kaiserpermanente.org/mas/formulary.html>**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Prescriber specialty: Neurologist Other: _____

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Please check the boxes that apply:

Initial Request Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

1. Is the member ≥ 18 years? **AND**
 No Yes
2. Does the member have a diagnosis of Neuropathic Heredofamilial Amyloidosis? **AND**
 No Yes
3. Does the member have a documented confirmed transthyretin (TTR) mutation from genetic testing? **AND**
 No Yes
4. Member does not have end stage renal disease (chronic kidney disease Stage 5) **AND**
 No Yes
5. Member has documented intolerance or contraindication to Onpattro?
 No Yes

*** Prior to treatment, review by Interregional Consultative Physician Panel is recommended.**

Continuation of Therapy:

1. The following assessments have been performed within the past 6 months: Medical research Council (MRC) strength testing scale (0-5), hand grip strength (with or without dynamometer), and 10-meter walk test (10MWT) and Timed Up and Go (TUG) test, if applicable **AND**
 No Yes
2. Karnofsky performance score ≥ 30 **AND**
 No Yes
3. Member has no significant clinical decline **AND**
 No Yes
4. Member has no development of cardiogenic shock requiring inotropic support **AND**
 No Yes
5. Patient is NOT in hospice care
 No Yes

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:

Date:

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