Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Tegsedi (inotersen sodium) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Tegsedi (inotersen sodium).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

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

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

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 not had a prior liver transplant, AND
   □ No □ Yes

6. Member does not have severe hepatic impairment [alanine transaminase (ALT) >2.5 times the upper limit of normal] and/or cirrhosis, AND
   □ No □ Yes

7. Member does not have hepatitis B or C infection, human immunodeficiency virus (HIV) infection, or active malignancy, AND
   □ No □ Yes

8. Member has documented intolerance or contraindication to Onpattro
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

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 –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

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

Provider Signature:	**Date:**