Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Wainua (eplontersen) 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 **Wainua (eplontersen)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans**.** Please complete all sections, incomplete forms will delay processing. 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 all sections are 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 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

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 prescriber a Neurologist?
   □ No □ Yes

2. Is the patient ≥18 years of age?
   □ No □ Yes

3. Does the patient have a diagnosis of Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis (hATTR-PN)?
   □ No □ Yes

4. Is there documented confirmed transthyretin (TTR) mutation from genetic testing?
   □ No □ Yes

5. Is Karnofsky performance score ≥50?
   □ No □ Yes

6. Does the patient have signs of large fiber neuropathy and/or clinically significant autonomic findings (e.g., orthostatic hypotension, tachycardia, bradycardia, etc.)?
   □ No □ Yes

7. Does the patient have objective weakness in motor strength exam consistent with diagnosis and with confirmation via electrodiagnostic studies (i.e., electromyogram, nerve conduction study)?
   □ No □ Yes

8. Is patient's eGFR ≥30 mL/min/1.73m^2 for coverage?
   □ No □ Yes

9. Is there confirmation that patient does NOT have any of the following?
   - Prior liver transplant
   - Severe hepatic impairment [alanine transaminase (ALT) >2.5 times the upper limit of normal] and/or cirrhosis
   - Active untreated infection [hepatitis C virus (HCV) infection, human immunodeficiency virus (HIV) infection], or active malignancy

   □ No □ Yes

10. Is there confirmation that patient is NOT pregnant or of childbearing age without adequate contraception?
    □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Has the following assessment been performed within the past 6 months:
   - Medical research Council (MRC) strength testing scale (0-5)

   □ No □ Yes

2. Does the patient have a Karnofsky performance score ≥30?
   □ No □ Yes

3. Is there confirmation that patient does NOT have any of the following conditions?
   - Significant clinical decline with life expectancy of <1 year
   - Cardiogenic shock requiring inotropic support
   - Severe renal or hepatic impairment within the last 6 months
   - Pregnancy
   - Hospice care

   □ No □ Yes

6 – Prescriber 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.

Prescriber Signature:	**Date:**