(Revised 1/2023)

blue of california

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Tegsedi J3490

Plan/Medical Group Name: Blue Shield of California

Plan Phone#: (800) 633-4581

☐ **Non-Urgent-** The Federal Employee Program has a **72- hour turn-around time on medications that requires Prior Authorization** according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information **FAX TO: 844-224-0226**

☐ **Urgent Request-** Please note, scheduling issues do not meet the definition of Urgent. ***Definition of an Urgent Request:*** An imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. **FAX TO: 844-224-0226**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name and HCPCS or CPT Code:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location: ☐ Physician's Office ☐ Outpatient Hospital Care	☐ Patient's Home ☐ Home Care Agency	☐ Long Term Care ☐ Ambulatory Infusion Center ☐ Other (explain):

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances or required under state and federal laws.

How many syringes will the patient need for an 84 day supply? _____ syringe(s) per 84 days

1. What is the patient's diagnosis? ❑ Polyneuropathy of Hereditary Transthyretin-mediated (hATTR) amyloidosis ❑ Other diagnosis (please specify): _____

2. Does the patient have a platelet count of greater than or equal to 100,000 cells per microliter? ❑Yes ❑No

3. Does the patient have an eGFR greater than or equal to 45 mL/min/1.73m2 ? ❑Yes ❑No

4. Does the prescriber agree to monitor platelet count, renal function (serum creatinine, eGFR, and urinalysis), and liver function (ALT, AST, and total bilirubin) during therapy with Tegsedi? ❑Yes ❑No

5. Does the prescriber agree to supplement the patient with the recommended daily allowance of Vitamin A if indicated? ❑Yes ❑No

6. Are both the prescriber and patient enrolled in the Tegsedi REMS program? ❑Yes ❑No

7. Will Tegsedi be used in combination with another *Prior Authorization (PA) medication for polyneuropathy caused by hATTR amyloidosis? ❑Yes* ❑No *If YES, please specify medication:
_____ *PA Medications: Amvuttra (vutrisiran), Onpattro (patisiran)

8. Has the patient been on Tegsedi continuously for the last 6 months, excluding samples? Please select answer below:

☐NO **– this is INITIATION of therapy, please answer the following questions**:

a. Has the patient's diagnosis been confirmed by genetic testing or tissue biopsy showing amyloid deposition? ❑Yes ❑No

b. Does the patient have a baseline score using the polyneuropathy disability (PND) scoring tool less than or equal to Stage IIIb? ☐Yes ☐No*

*If NO, does the patient have a baseline score of Stage 1 or 2 using the FAP scoring tool? ❑Yes ❑No

c. Does the patient have New York Heart Association (NYHA) class 3 or 4 heat failure? ❑Yes ❑No

d. Does the patient have a sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)? ☐Yes ☐No

e. Has the patient had a prior liver transplantation? ☐Yes ☐No

f. Is Tegsedi being prescribed by or in consultation with a neurologist, or a specialist in the treatment of the patient's diagnosis? ☐Yes ☐No

❑YES – **this is a PA renewal for CONTINUATION of therapy**, please answer the following question:

a. Has the patient's condition improved or stabilized with Tegsedi? ❑Yes ❑No

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number (_____)_____

Approved Denied Comments/Information Requested: _____