HIGHMARK WHOLECARE

Updated: 08/2026
PARP Approved: 09/2026

Prior Authorization Criteria

# Onpattro (patisiran) and Amvuttra (vutrisiran)

All requests for Onpattro (patisiran) and Amvuttra (vutrisiran) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis and the following criteria is met:

- Member must be 18 years of age and older
- Prescribed by or in consultation with a neurologist or a specialist in the treatment of amyloidosis
- Diagnosis of hATTR amyloidosis with polyneuropathy confirmed by the presence of a transthyretin (TTR) gene mutation (e.g., V30M, A97S, T60A, E89Q, S50R)
- Documentation of one of the following baseline tests:
    - modified Neuropathy Impairment Scale +7 (mNIS+7) composite score
    - polyneuropathy disability (PND) score of ≤ IIIb
    - familial amyloid polyneuropathy (FAP) Stage 1 or 2
- Member has clinical signs and symptoms of polyneuropathy (i.e. weakness, sensory loss, decreased motor strength, decreased gait speed)
- Other causes of peripheral neuropathy have been assessed and ruled out
- Member will not be receiving the requested medication in combination with the following:
    - oligonucleotide agents [Onpattro (patisiran)]
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Documentation of a therapeutic response as evidenced by stabilization or improvement (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.) from baseline in one of the following:
        - mNIS+7 score
        - polyneuropathy disability (PND) score of ≤ IIIb
        - familial amyloid polyneuropathy (FAP) Stage 1 or 2
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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Updated: 08/2026
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# Onpattro (patisiran) and Amvuttra (vutrisiran)
## PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

### PROVIDER INFORMATION

| | |
|---|---|
| Requesting Provider: | Provider NPI: |
| Provider Specialty: | Office Contact: |
| State license #: | Office NPI: |
| Office Address: | Office Phone: |
| | Office Fax: |

### MEMBER INFORMATION

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

### REQUESTED DRUG INFORMATION

| | | |
|---|---|---|
| Medication: | Strength: | |
| Directions: | Quantity: | Refills: |
| Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated: | |

### Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

### Place of Service Information

| | |
|---|---|
| Name: | NPI: |
| Address: | Phone: |

### MEDICAL HISTORY (Complete for ALL requests)

| | |
|---|---|
| Diagnosis: | ICD Code: |

Documented TTR mutation: _____

Does the member have a baseline polyneuropathy disability (PND) score ≤ IIIb, OR a baseline familial amyloid polyneuropathy (FAP) Stage 1 or 2 OR a modified Neuropathy Impairment Scale +7 (mNIS+7) composite score? ☐ Yes ☐ No

Does the member have clinical signs and symptoms of polyneuropathy? ☐ Yes ☐ No

Have other causes of peripheral neuropathy have been assessed and ruled out? ☐ Yes ☐ No

Will the member be receiving the requested medication in combination with a oligonucleotide agent? ☐ Yes ☐ No

### CURRENT or PREVIOUS THERAPY

| Medication Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why/Current) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

Has the member had a therapeutic response as evidenced by stabilization or improvement (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.) from baseline in one of the following?

- mNIS+7 score
- polyneuropathy disability (PND) score of ≤ IIIb
- familial amyloid polyneuropathy (FAP) Stage 1 or 2

Please describe:

***continued on next page***

**Onpattro (patisiran) and Amvuttra (vutrisiran)**
**PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
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| **MEMBER INFORMATION** | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

| **SUPPORTING INFORMATION or CLINICAL RATIONALE** |
|---|
| |
| |
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| |
| |

| **Prescribing Provider Signature** | Date |
|---|---|
| | |