HIGHMARK HEALTH OPTIONS

Updated: 05/2025
DMMA Approved: 06/2025

Request for Prior Authorization for Selective Transthyretin (TTR) Stabilizers
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Selective Transthyretin (TTR) stabilizers require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Selective Transthyretin (TTR) stabilizers Prior Authorization Criteria:

Selective Transthyretin (TTR) stabilizers include: Vyndaqel (tafamidis meglumine), Vyndamax (tafamidis), Attruby (acoramidis) and Amvuttra (vutrisiran).

Coverage may be provided with a diagnosis of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) and the following criteria is met:

- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- The diagnosis is confirmed by presence of amyloid deposits on biopsy analysis from cardiac or non-cardiac sites (e.g., fat aspirate, gastrointestinal sites, salivary glands, bone marrow) or by technetium-labeled bone scintigraphy tracing
- Cardiac involvement was confirmed by echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 mm)
- For members with hereditary ATTR-CM, presence of a mutation of the TTR gene was confirmed
- For members with wild type ATTR-CM, presence of transthyretin precursor proteins was confirmed by immunohistochemical analysis, scintigraphy, or mass spectrometry
- The member exhibits clinical symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)
- Member has a New York Heart Association Class I, II or III heart failure
- The requested medication will not be used in combination with tetramer stabilizers (e.g. diflunisal)
- Must be prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
- Member does not have a history of liver or heart transplantation
- 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 confirming the member demonstrates a beneficial response to treatment (e.g., improvement on the 6-minute walk test, the Kansas City Cardiomyopathy Questionnaire–Overall Summary (KCCQ-OS) score, cardiovascular-

related hospitalizations, NYHA classification of heart failure, left ventricular stroke volume, NT-proBNP level)

- **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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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PRIOR AUTHORIZATION FORM- PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:0am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
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:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

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: ☐ Cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)
☐ Other: _____ ICD-10 Code: _____
Has the diagnosis been confirmed by presence of amyloid deposits on biopsy analysis from cardiac or non-cardiac sites (e.g., fat aspirate, gastrointestinal sites, salivary glands, bone marrow) or by technetium-labeled bone scintigraphy tracing?
☐ Yes ☐ No
Has cardiac involvement been confirmed by echocardiography or cardiac magnetic resonance imaging? ☐ Yes ☐ No
For members with hereditary ATTR-CM, has the presence of a TTR gene mutation been confirmed? ☐ Yes ☐ No
For members with wild type ATTR-CM, has the presence of transthyretin precursor proteins been confirmed by immunohistochemical analysis, scintigraphy, or mass spectrometry? ☐ Yes ☐ No
Does the member exhibit clinical symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)? ☐ Yes ☐ No
Does the member have a New York Heart Association Class I, II or III heart failure? ☐ Yes ☐ No
Will the member be using the requested medication in combination with tetramer stabilizers (e.g. diflunisal)? ☐ Yes ☐ No
Does the member have a history of liver or heart transplantation? ☐ Yes ☐ No
Is the medication being prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

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SELECTIVE TRANSTHYRETIN (TTR) STABILIZERS
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 Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:00am to 7:00pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REAUTHORIZATION

Is there documentation confirming the member has demonstrated a beneficial response to treatment (e.g., improvement on the 6-minute walk test, Kansas City Cardiomyopathy Questionnaire–Overall Summary (KCCQ-OS) score, cardiovascular-related hospitalizations, NYHA classification of heart failure, left ventricular stroke volume, NT-proBNP level)? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date