Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Amvuttra
## (vutrisiran sodium)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication requested:**
☐ Amvuttra 25 mg/0.5 mL syringe
☐ other (please specify):

ICD10:

Directions for use: Dose: Quantity:
Duration of therapy: Frequency of therapy:
CPT Codes:

Is this a new start or continuation of therapy with the requested medication? If your patient has been taking samples, please pick "new start."
☐ New start
☐ Continuation of therapy

**Where will this medication be obtained?**
☐ Orsini
☐ US Bio
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

**Facility and/or doctor dispensing and administering medication:**
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

**Where will this drug be administered?**
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:*** *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

**What is your patient's diagnosis?**

☐ Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR)
☐ Other (please specify):

**Clinical Information:**

****This drug REQUIRES supportive documentation for ALL answers, including genetic testing, chart notes, etc.****

Does the patient have a transthyretin pathogenic variant that is confirmed by genetic testing? ☐ Yes ☐ No

Does the patient have symptomatic polyneuropathy (Examples of symptomatic polyneuropathy include reduced motor strength/coordination, and impaired sensation [for example, pain, temperature, vibration, touch])? ☐ Yes ☐ No

Does the patient have a history of a liver transplant? ☐ Yes ☐ No

Is the requested medication prescribed by (or in consultation with) a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis? ☐ Yes ☐ No

Will the requested medication be used concomitantly with Onpattro (patisiran intravenous infusion), Tegsedi (inotersen subcutaneous injection), Wainua (eplontersen subcutaneous injection) or a Tafamidis product (examples - Vyndaqel and Vyndamax)? ☐ Yes ☐ No

**Additional Pertinent Information:** *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer 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:**_____ **Date:**_____

**Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.**

*Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.*

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