PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Tegsedi - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Tegsedi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Tegsedi (Inotersen)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

[If yes, skip to question 11.]

2. Does the patient have a diagnosis of hereditary transthyretin-mediated amyloidosis with polyneuropathy? Y N

NOTE: Submission of medical records is required.

[If no, no further questions.]

3. Is the patient 18 years of age or older? Y N

	[If no, no further questions.]		
4.	Has the transthyretin (TTR) mutation been confirmed through genetic testing?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Does the patient have documented clinical signs and symptoms of the disease (such as motor disability, peripheral polyneuropathy, or autonomic neuropathy)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
6.	Is there documentation of one of the following: A) Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb, B) Patient has a baseline familial amyloidotic polyneuropathy (FAP) of Stage 1 or 2, C) Patient has a baseline neuropathy impairment score (NIS) between 10 and 130?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Does the patient have a documented baseline platelet count greater than or equal to 100 x 10 to the 9th per liter?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
8.	Does the patient have a documented urinary protein to creatinine ratio (UPCR) of 1000 milligrams per gram or higher?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
9.	Is the requested drug being prescribed by or in consultation with a neurologist?	Y N	
	[If no, no further questions.]		
10.	Does the patient have any of the following exclusions to therapy: A) History of acute glomerulonephritis caused by Tegsedi, B) Platelet count less than 100 x 10 to the 9th per liter, C) Concurrent use with Tafamidis meglumine, or oligonucleotide agents, such as Onpattro (patisiran), D) History of liver transplant, E) Severe renal impairment or end stage renal disease (ESRD), F) Moderate to severe hepatic impairment, G) Sensorimotor or autonomic neuropathy not related to hereditary transthyretin-mediated (hATTR) amyloidosis?	Y N	
	[No further questions.]		
11.	Is there documentation showing clinical benefit from treatment evidenced by improved neurologic impairment, motor function, quality of life, or slowing of disease progression, as well as improvement or stabilization of one of the following: A) Polyneuropathy disability (PND) score	Y N	

less than or equal to IIIb, B) Familial amyloidotic polyneuropathy (FAP) of Stage 1 or 2, C) Neuropathy impairment score (NIS) between 10 and 130?	
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Does the patient have any of the following exclusions to therapy: A) History of acute glomerulonephritis caused by Tegsedi, B) Platelet count less than 100 x 10 to the 9th per liter, C) Concurrent use with Tafamidis meglumine, or oligonucleotide agents, such as Onpattro (patisiran), D) History of liver transplant, E) Severe renal impairment or end stage renal disease (ESRD), F) Moderate to severe hepatic impairment, G) Sensorimotor or autonomic neuropathy not related to hereditary transthyretin-mediated (hATTR) amyloidosis?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date