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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Vyndamax - 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 Vyndamax - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Vyndamax (tafamidis)

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

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 10.]

2. Does the patient have a documented diagnosis of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)? Y N _____

	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
3.	Is the diagnosis of wild type hereditary transthyretin-mediated amyloidosis (ATTR-CM) supported with documentation for one of the following: A) tissue biopsy supporting histologic confirmation of ATTR amyloid deposits, or B) genetic testing that shows the patient has a hereditary variant in the TTR mutation (such as Val122Ile, or Val30Met mutations)?	Y N	
	NOTE: Submission of medical records is required.		
	[If yes, skip to question 5.]		
4.	Is there documentation for all of the following: A) grade 2 or 3 cardiac retention of radionuclide-tagged bisphosphonate on bone scintigraphy (99mTc-DPD/99mTc-PYP/99mTc-HMDP), B) absence of a detectable monoclonal protein in serum and urine immunofixation electrophoresis (IFE) and serum free light chain (sFLC) assay, and C) echocardiogram, electrocardiogram, or cardiac magnetic resonance imaging that suggest cardiac amyloidosis?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Does the patient have either of the following: A) New York Heart Association (NYHA) Functional Class IV heart failure symptoms, or B) a history of liver or heart transplant?	Y N	
	[If yes, no further questions.]		
6.	Is there documentation that the patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure symptoms?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Does the patient have documented clinical signs and symptoms of cardiomyopathy (such as dyspnea, peripheral edema, hepatomegaly, ascites, etc.)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
8.	Is or has the prescriber consulted with a cardiologist?	Y N	
	[If no, no further questions.]		
9.	Is the patient 18 years of age or older?	Y N	
	[No further questions.]		
10.	Is there documentation showing the patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure, but has experienced clinical improvements from treatment?	Y N	
	NOTE: Submission of medical records is required.		

[If no, no further questions.]	
11. Is the patient's clinical improvement evidenced by at least one of the following: A) improvement of clinical signs and symptoms, B) slowing of cardiomyopathy disease progression, C) increased quality of life activities, D) reduced hospital admissions related to the condition?	Y N
NOTE: Submission of medical records is required.	

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