

Prior Authorization Request Form for
 tafamidis meglumine (**Vyndaqel**), tafamidis (**Vyndamax**)



JOHNS HOPKINS
 MEDICINE
 JOHNS HOPKINS
 HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
 Applicable Progress Notes to:
 (410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

1 Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID # _____ Phone #: _____
 Date of Birth: _____ Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient have a diagnosis of wild type or hereditary transthyretin-mediated amyloidosis?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the requested medication being prescribed by or in consultation with a specialist who manages hereditary transthyretin amyloidosis (for example, cardiologist, geneticist, or neurologist)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the patient female with childbearing potential?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Sign and date below
5. Is the patient pregnant or actively trying to become pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 6
6. Is the patient breastfeeding?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 7
7. Will the patient take highly effective contraception during treatment and for 1 month after the last dose?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

3 _____ [29 January 2020]
 Prescriber Signature Date

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: