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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Onpattro™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Does the patient have transthyretin (TTR) mutation (e.g., V30M)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is Onpattro prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has one of the following:					
<input type="checkbox"/> Baseline polyneuropathy disability (PND) score ≤ IIIb					
<input type="checkbox"/> Baseline familial amyloidotic polyneuropathy (FAP) stage 1 or 2					
<input type="checkbox"/> Baseline neuropathy impairment score (NIS) between 10 and 130					
Has the patient had a liver transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Has the patient demonstrated benefit from Onpattro therapy (e.g., improved neurologic impairment, slowing of disease progression, quality of life assessment)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has one of the following:					
<input type="checkbox"/> Patient continues to have a PND score ≤ IIIb					
<input type="checkbox"/> Patient continues to have a FAP stage of 1 or 2					
<input type="checkbox"/> Patient continues to have a NIS between 10 and 130					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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Office use only: Onpattro_Comm_2018Dec-W