OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Tegsedi™ Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have transthyretin (TTR) mutation (e.g., V30M)? ❑ **Yes** ❑ **No**

Is Tegsedi prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Select if the patient has one of the following:

- ❑ Baseline polyneuropathy disability (PND) score ≤ IIIb
- ❑ Baseline familial amyloidotic polyneuropathy (FAP) stage 1 or 2
- ❑ Baseline neuropathy impairment score (NIS) between 10 and 130

Has the patient had a liver transplant? ❑ **Yes** ❑ **No**

Does the patient have clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy)? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient demonstrated benefit from Tegsedi therapy (e.g., improved neurologic impairment, slowing of disease progression, quality of life assessment)? ❑ **Yes** ❑ **No**

Select if the patient has one of the following:

- ❑ Patient continues to have a PND score ≤ IIIb
- ❑ Patient continues to have a FAP stage of 1 or 2
- ❑ 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.

Office use only: Tegsedi_Comm_2019Jan-W