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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

Tegsedi™ Prior Authorization Request Form

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

Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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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 <small>(required)</small>
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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 <small>(required)</small>
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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.

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