

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Amvuttra

(vutrisiran sodium)

PHYSICIA	PATIENT INFORMATION							
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with					
Specialty:	* DEA, NP	PI or TIN:	the outcome of our review unless all asterisked (*) items on this form are completed.*					
Office Contact Person:			* Patient Name:					
Office Phone:			* Cigna ID: * Date of Birth:					
Office Fax:			* Patient Street Address:					
Office Street Address:			City:	State:			Zip:	
City:	State:	Zip:	Patient Phone:	1			,	
Urgency: ☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)								
Medication requested: ☐ Amvuttra 25 mg/0.5 mL syringe ☐ other (please specify):								
ICD10:								
Directions for use: Duration of therapy: CPT Codes: Dose: Quantity: Quantity:								
Is this a new start or continuation of therapy with the requested medication? If your patient has been taking samples, please pick "new start." New start Continuation of therapy								
(if continuation of therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No								
(if no) Please provide support for continued use.								
Where will this medication be obtained?								
☐ Orsini☐ US Bio☐ Hospital Outpatient☐ Retail pharmacy☐ Other (please specify):				☐ Home Hea☐ Physician' form)			on vendor ing on a medical claim	
Facility and/or doctor dispensing and administering medication:								
Facility Name:		State:	٦	Гах ID#:				
Address (City, State, Zip Code):								
1								

What is your patient's diagnosis?	
☐ Cardiomyopathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) in the Absence of Polyneuropathy Sympel Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) Polyneuropathy Not Related to of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) Other (please specify):	ptoms
Clinical Information:	
This drug REQUIRES supportive documentation for ALL answers, including genetic testing, chart i	notes, etc.
Was the patient's diagnosis confirmed by genetic test results showing a transthyretin (TTR) genetic variant (pathogenic pathogenic variant)?	or likely] Yes
ls there documentation the patient has symptomatic polyneuropathy confirmed by history and clinical exam, electromyoconduction velocity?	graphy, or nerve]Yes
Have other causes of neuropathy have been excluded (for example, diabetes)?] Yes 🗌 No
Has the patient had a liver transplant?] Yes 🗌 No
Is the requested medication prescribed by (or in consultation with) a neurologist, geneticist, or a physician who specializ treatment of amyloidosis?	es in the]Yes
Will the requested medication be used concomitantly with Onpattro (patisiran intravenous injection), Tegsedi (inotersen injection), Wainua (eplontersen subcutaneous injection) or a Tafamidis product (examples - Vyndaqel and Vyndamax)?	subcutaneous] Yes
Additional Pertinent Information: (please include clinical reasons for drug, relevant lab values, etc.)	
Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Hea its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the reported on this form. Prescriber Signature: Date:	ulth Plan or insurer ne information
Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScript	ts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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