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

Vyndamax (tafamidis)
Vyndaqel (tafamidis meglumine)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
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:		

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:
☐ Vyndaqel 20mg oral capsules ☐ Vyndamax 61mg oral capsules ☐ Other *(please specify)*:

Directions for use: Dose: Quantity:

Duration of therapy: ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with samples of this drug, please choose new start of therapy. ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a documented beneficial clinical response (for example, reduction in cardiovascular-related hospitalizations, improvement or stabilization in 6-Minute Walk Test, improvement in symptom burden and/or frequency, improvement in quality of life) to treatment with this drug? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Diagnosis related to use:
☐ cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)
☐ Other *(please specify)*:

Clinical Information:
****These medications require supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

Has genetic testing identified a transthyretin (TTR) mutation (pathogenic or likely pathogenic variant in TTR; for example, Val122Ile mutation, Thr60Ala mutation) or wild-type amyloidosis in this patient? ☐ Yes ☐ No
(if no or unknown) Did the patient have a cardiac tissue biopsy that found amyloid deposits? ☐ Yes ☐ No

Was the patient's cardiac diagnosis confirmed by a technetium-99m pyrophosphate (Tc-99m PYP) imaging scan demonstrating Grade 2 or 3 myocardial uptake? ☐ Yes ☐ No
(if no or unknown) Did the patient have a cardiac tissue biopsy that found amyloid deposits? ☐ Yes ☐ No

Does your patient have documented clinical signs and/or symptoms of heart failure? ☐ Yes ☐ No

(if yes) Please indicate your patient's heart failure severity by selecting their New York Heart Association class.
☐ Class I (Mild)
☐ Class II (Mild)
☐ Class III (Moderate)
☐ Class IV (Severe)

Has this drug been prescribed by, or in consultation with, a cardiologist or a physician who specializes in the treatment of amyloidosis?
☐ Yes ☐ No

While taking this drug, will your patient also receive Onpattro (patisiran), Tegsedi (inotersen), or another tafamidis product (Vyndamax/Vyndaqel)?
☐ Yes or Possibly ☐ No

(if yes) Please explain and provide clinical rationale for concurrent use of these drugs.

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts 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.

V061520