Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Transthyretin Agents – Tegsedi (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Transthyretin Agents – Tegsedi (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
TEGSEDI 284MG/1.5ML SYRINGE – PACK 1	TEGSEDI 284MG/1.5ML SYRINGE – PACK 4

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the medication being prescribed by, or in consultation with, a neurologist or provider that specializes in the treatment of transthyretin-mediated amyloidosis? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Is the patient's platelet count greater than or equal to 100 X 10^9/L? Y N
   If the answer to this question is yes, go to question 6.
   If the answer to this question is no, denied.

6. Is the patient's urine protein to creatinine ration (UPCR) less than 1000mg/g? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Is the requested quantity less than or equal to the recommended dosing guidelines (see Table A below)? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Will the patient have concurrent therapy with patisiran or tafamidis? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

9. Is this request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, approved for 365 days.

10. Has the patient failed a treatment trial with at least 1 preferred agent(s)? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 11.

11. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 12.

12. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, denied.

Table A:

Recommended Dosing Guidelines	
Label Name	**Recommended Dose**
Tegsedi 284mg/1.5mL syringe	284mg (1 syringe) SQ weekly

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date