BlueCross BlueShield
Federal Employee Program

(inotersen) TEGSEDI PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tegsedi (inotersen)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many syringes will the patient need for an 84 day supply? _____ syringe(s) per 84 days

1. What is the patient's diagnosis?
   - ❑ Polyneuropathy of Hereditary Transthyretin-mediated (hATTR) amyloidosis
   - ❑ Other diagnosis ***(please specify)***: _____
2. Does the patient have a platelet count of greater than or equal to 100,000 cells per microliter? ❑Yes ❑No
3. Does the patient have an eGFR greater than or equal to 45 mL/min/1.73m^2? ❑Yes ❑No
4. Does the prescriber agree to monitor platelet count, renal function (serum creatinine, eGFR, and urinalysis), and liver function (ALT, AST, and total bilirubin) during therapy with Tegsedi? ❑Yes ❑No
5. Does the prescriber agree to supplement the patient with the recommended daily allowance of Vitamin A if indicated? ❑Yes ❑No
6. Are both the prescriber and patient enrolled in the Tegsedi REMS program? ❑Yes ❑No
7. Will Tegsedi be used in combination with another *****Prior Authorization (PA) medication for polyneuropathy caused by hATTR amyloidosis? ❑Yes***** ❑No

   ****If YES***, please specify medication: _____

   ****PA Medications: Amvuttra (vutrisiran), Onpattro (patisiran)***
8. Has the patient been on Tegsedi continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Has the patient's diagnosis been confirmed by genetic testing or tissue biopsy showing amyloid deposition? ❑Yes ❑No
   - b. Does the patient have a baseline score using the polyneuropathy disability (PND) scoring tool less than or equal to Stage IIIb? ❑Yes ❑No*****

     ****If NO***, does the patient have a baseline score of Stage 1 or 2 using the FAP scoring tool? ❑Yes ❑No
   - c. Does the patient have New York Heart Association (NYHA) class 3 or 4 heat failure? ❑Yes ❑No
   - d. Does the patient have a sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)? ❑Yes ❑No
   - e. Has the patient had a prior liver transplantation? ❑Yes ❑No
   - f. Is Tegsedi being prescribed by or in consultation with a neurologist, or a specialist in the treatment of the patient's diagnosis? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   - a. Has the patient's condition improved or stabilized with Tegsedi? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Tegsedi – FEP MD Fax Form Revised 11/18/2022