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

Amvuttra
(vutrisiran sodium)

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:
☐ Amvuttra 25 mg/0.5 mL syringe
☐ other (please specify):

ICD10:

Directions for use: Dose: Quantity:
Duration of therapy: Frequency of therapy:
CPT Codes:

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

Where will this medication be obtained?
☐ Orsini
☐ US Bio
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

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

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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

What is your patient's diagnosis?

☐ Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR)
☐ Other (please specify):

Clinical Information:

****This drug REQUIRES supportive documentation for ALL answers, including genetic testing, chart notes, etc.****

Is documentation being provided that the patient has a transthyretin pathogenic variant as confirmed by genetic testing? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

Is documentation being provided that the patient has symptomatic polyneuropathy? Note: Examples of symptomatic polyneuropathy include reduced motor strength/coordination, and impaired sensation (for example, pain, temperature, vibration, touch). Examples of assessments for symptomatic disease include history and clinical exam, electromyography, or nerve conduction velocity testing. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

Does the patient have a history of a liver transplant? ☐ Yes ☐ No

Is the requested medication prescribed by (or in consultation with) a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis? ☐ Yes ☐ No

Is/Will this medication (be)ing used in combination with other medications indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (for example, Attruby [acoramidis tablets], Onpattro [patisiran intravenous infusion], Tegsedi [inotersen subcutaneous injection], Wainua [eplontersen subcutaneous injection], or a tafamidis product)? ☐ Yes ☐ No

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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.

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