TEXAS MEDICAID
Clinical Edit Prior Authorization
tafamidis (VYNDAMAX) and tafamidis meglumine (VYNDAQEL)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the cardiac/non-cardiac tissue biopsy confirm the presence of amyloid deposits? [Manual Step]

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Has the diagnosis been documented by confirmation of transthyretin (TTR) precursor protein (wild type ATTR-CM) or confirmation of a TTR gene mutation (hereditary ATTR-CM)? [Manual Step]

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a diagnosis of New York Heart Association (NYHA) Functional Class (FC) IV heart failure? [Manual Step]

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a history of heart or liver transplant in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #7)

7. Is the requested quantity less than or equal to (≤) the recommended dosing guidelines?

Recommended dosage is 1 capsule daily for VYNDAMAX capsule and 4 capsules daily for VYNDAQUEL capsule.

☐ Yes (Go to #8) ☐ No (Deny)

8. Will the client have concurrent therapy with inotersen (TEGSEDI) or patisiran (ONPATTRO)?

☐ Yes (Deny) ☐ No (Approve - 365 days)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.