aetna®

Tegsedi™ (inotersen) Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *Check One:* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Neurologist ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Tegsedi (inotersen): Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Polyneuropathy

☐ Yes ☐ No Is there documentation the patient is enrolled in the Tegsedi (inotersen) Risk Evaluation and Mitigation Strategy (REMS) program?
☐ Yes ☐ No Will Tegsedi (inotersen) be used concomitantly with Onpattro (patisiran)?
☐ Yes ☐ No Is the polyneuropathy caused by hereditary transthyretin-mediated amyloidosis (hATTR)?
☐ Yes ☐ No Is the patient symptomatic?
☐ Yes ☐ No Does the patient have a documented TTR gene mutation?
→ ☐ Yes ☐ No Was the gene mutation confirmed by genotyping?
☐ Yes ☐ No Is there documentation of amyloid deposit confirmed by biopsy?

Please indicate the familial amyloid polyneuropathy (FAP) stage:
☐ Stage 0 (no symptoms)
☐ Stage I (unimpaired ambulation; mostly mild sensory, motor, and autonomic neuropathy in the lower limbs)
☐ Stage II (assistance with ambulation required; mostly moderate impairment progression to the lower limbs, upper limbs, and trunk)
☐ Stage III (wheelchair-bound or bedridden; severe sensory, motor, and autonomic involvement of all limbs)

Please indicate the platelet count:
☐ Less than or equal to 99 x 10^9/L ☐ Greater than or equal to 100 x 10^9/L

Please indicate the urinary protein to creatinine ratio (UPCR):
☐ Less than 1000 mg/g ☐ 1000 mg/g ☐ Greater than 1000mg/g

Please indicate the estimated glomerular filtration rate (eGFR):
☐ Less than or equal to 44 mL/minute/1.73 m2 ☐ Greater than or equal to 45 mL/minute/1.73 m2

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation of Therapy (clinical documentation required):

☐ Yes ☐ No Will the initial injection be administered under the supervision of a qualified healthcare provider?

For Continuation of Therapy (clinical documentation required):

☐ Yes ☐ No Is there clinical documentation indicating that there is disease stability or improvement?

→ Please indicate the disease stability or improvement: ☐ Decrease in neuropathic pain from baseline
☐ Improved motor function from baseline ☐ Improved quality of life assessment from baseline
☐ Other: Please explain: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.