



Onpattro® (patisiran) Injectable Medication Precertification Request

Page 1 of 2

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

Aetna Precertification Notification

Phone: **1-866-752-7021** (TTY: 711)

FAX: **1-888-267-3277**

For Medicare Advantage Part B:

Please Use Medicare Request Form

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:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms				Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Neurologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: (Patient selected choice) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Onpattro (patisiran) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ **Secondary 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 for all requests):

- ☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____
☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____
- ☐ Yes ☐ No Does the patient have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR) (transthyretin-type familial amyloid polyneuropathy (ATTR-FAP))?
- ☐ Yes ☐ No Was the diagnosis confirmed by detection of a mutation of the TTR gene?
- ☐ Yes ☐ No Does the patient exhibit clinical manifestations of polyneuropathy of hereditary transthyretin-mediated amyloidosis (ATTR-FAP) (e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION – (continued) Required clinical information must be completed in its entirety for all precertification requests.

- ☐ Yes ☐ No Will the requested medication be used in combination with inotersen (Tegsedi), vutrisiran (Amvuttra) or tafamidis (Vyndaqel, Vyndamax)?
- ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with any of the following: a) neurologist, b) geneticist, or c) physician specializing in the treatment of amyloidosis?

Continuation Requests (clinical documentation required for all requests):

- ☐ Yes ☐ No Has the patient demonstrated a beneficial response to the requested medication therapy compared to baseline (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength)?

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.