



# Wainua™ (eplontersen) Medication Precertification Request

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(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 Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Geneticist <input type="checkbox"/> Neurologist <input type="checkbox"/> Other: _____					

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

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

### E. PRODUCT INFORMATION

**Request is for:** Wainua (eplontersen) **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):

- Yes  No Does the patient have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis (transthyretin-type familial amyloid polyneuropathy [ATTR-FAP])?
- Yes  No Was the diagnosis confirmed by detection of a mutation in 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)?
- Yes  No Is the patient a liver transplant recipient?
- Yes  No Will the requested medication be used in combination with any other medication approved for the treatment of hereditary transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpatro, Tegsedi, Vyndamax, Vyndaqel)?
- Yes  No Will the requested medication be prescribed by or in consultation with any of the following: a) Neurologist, b) Geneticist, or c) Physician specializing in the treatment of amyloidosis?

#### For Continuation Requests (clinical documentation required):

- Yes  No Has the patient demonstrated a beneficial response to treatment with the requested medication 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.