



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Wainua - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. The member will not be receiving Wainua in combination with vutrisiran (Amvuttra), patisiran (Onpattro), inotersen (Tegsedi), tafamidis meglumine (Vyndaqel), tafamidis (Vyndamax), or acoramidis (Attruby).

Yes

No

Q2. Is the request for a reauthorization of Wainua?

Yes

No

Q3. There is a documented positive clinical response to Wainua therapy from baseline (e.g., improved neurologic impairment, ambulation, motor function, and/or quality of life, slowing of disease progression, etc.).

Yes

No

Q4. The member is 18 years of age or older.

Yes

No

Q5. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. The member has a documented diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis as evidenced by transthyretin variant by genotyping.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. The member has documentation of one of the following:	
<input type="checkbox"/> a. Baseline polyneuropathy disability (PND) score less than or equal to IIIb	
<input type="checkbox"/> b. Baseline FAP Stage 1 or 2	
<input type="checkbox"/> c. Baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130	
Q8. The member has documented clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.).	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. The drug is being prescribed by or in consultation with a neurologist or physician who specializes in the treatment of amyloidosis.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. The member does not have evidence of either of the following:	
<input type="checkbox"/> a. Prior or planned liver transplant	<input type="checkbox"/> b. Sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)
Q11. Additional Information:	

Prescriber Signature

Date

v2026-06



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