



**GEORGIA MEDICAID FEE-FOR-SERVICE  
HEREDITARY TRANSTHYRETIN AMLOIDOSIS AGENTS PA SUMMARY**

Preferred	Non-Preferred
N/A	Tegsedi (inotersen)

**LENGTH OF AUTHORIZATION:** 1 Year

**PA CRITERIA:**

- ❖ Approvable for members 18 years of age or older with a diagnosis of polyneuropathy of hereditary transthyretin (hATTR)-mediated amyloidosis who are stage 1 or 2 and have a transthyretin (TTR) mutation confirmed by genotyping

*AND*

- ❖ When prescribed by or in consultation with a neurologist or physician who specializes in the treatment of hereditary transthyretin (hATTR)-mediated amyloidosis

*AND*

- ❖ The prescriber, member and pharmacy are enrolled in the Tegsedi Risk Evaluation and Mitigation Strategy (REMS) program.

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process by calling **OptumRx at 1-866-525-5827**.

**PREFERRED DRUG LIST:**

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL List.