



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

Preferred	Non-Preferred
Attruby (acoramidis)* Vyndamax (tafamidis)* Vyndaqel (tafamidis meglumine)*	Tegsedi (inotersen) Wainua (eplontersen)

*preferred but requires PA

LENGTH OF AUTHORIZATION: 1 year

NOTE: Attruby, Vyndaqel and Vyndamax are preferred but require prior authorization.

PA CRITERIA:

Attruby, Vyndamax and Vyndaqel

- ❖ Approvable for members 18 years of age or older with a diagnosis of cardiomyopathy of wild type (ATTRwt) or hereditary transthyretin (hATTR)-mediated amyloidosis confirmed by amyloid deposits showing cardiac involvement who have New York Heart Association (NYHA) functional class I, II or III *AND*
- ❖ Member has signs and symptoms of heart failure (e.g., dyspnea, edema) or a history of heart failure, with at least one prior hospitalization for heart failure *AND*
- ❖ Medication is being prescribed by or in consultation with a cardiologist or other specialist in the treatment of hereditary transthyretin-mediated amyloidosis.

Tegsedi

- ❖ Approvable for members 18 years of age or older with a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis who are stage 1 or 2 and have a transthyretin (TTR) mutation confirmed by genotyping as well as amyloid deposits confirmed by biopsy *AND*
- ❖ Medication is being prescribed by or in consultation with a neurologist or other specialist in the treatment of hereditary transthyretin-mediated amyloidosis *AND*
- ❖ Prescriber, member and pharmacy are enrolled in the Tegsedi Risk Evaluation and Mitigation Strategy (REMS) program.

Wainua

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



- ❖ Medication is being prescribed by or in consultation with a neurologist or other specialist in the treatment of hereditary transthyretin-mediated amyloidosis.

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 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, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.