Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Wainua

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. The member has a documented diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis as evidenced by transthyretin variant by genotyping.

☐ Yes ☐ No

Q7. The member has documentation of one of the following:

☐ a. Baseline polyneuropathy disability (PND) score IIIb
☐ b. Baseline FAP Stage 1 or 2
☐ c. Baseline neuropathy impairment (NIS) score 10 and 130

Q8. The member has documented clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.).

☐ Yes ☐ No

Q9. The drug is being prescribed by or in consultation with a neurologist or physician who specializes in the treatment of amyloidosis.

☐ Yes ☐ No

Q10. The member does not have evidence of either of the following:

☐ a. Prior or planned liver transplant

☐ b. Sensorimotor or autonomic neuropathy not related to hATTR amyloidosis (monoclonal gammopathy, autoimmune disease, etc.)

Q11. Additional Information:

Prescriber Signature

Date

v2026