NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of
Tafamidis (Vyndamax) and Tafamidis Meglumine (Vyndaqel)

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

REQUESTED DRUG

☐ Tafamidis (Vyndamax 61 mg) ☐ Tafamidis Meglumine (Vyndaqel 20 mg)

INITIAL REQUEST

For the treatment of cardiomyopathy in adult patients with documented hereditary or wild-type transthyretin-mediated amyloidosis (ATTR) who meet ALL of the following criteria:

☐ New York Heart Association (NYHA) class I to III heart failure
☐ At least one prior hospitalization for heart failure or clinical evidence of heart failure that required treatment with a diuretic
☐ Has not previously undergone a heart or liver transplant
☐ Does not have an implanted cardiac mechanical assist device (CMAD)

Clinical Notes (Please complete the section corresponding to the patient's diagnosis):

☐ **Wild-type ATTR-cardiomyopathy (CM) consists of ALL of the following:**
- ☐ Absence of a variant transthyretin (TTR) genotype
- ☐ TTR precursor protein identification by immunohistochemistry, scintigraphy, or mass spectrometer
- ☐ Evidence of cardiac involvement by echocardiography with end-diastolic interventricular septal wall thickness greater than 12 mm
- ☐ Presence of amyloid deposits in biopsy tissue (fat aspirate, salivary gland, median nerve connection tissue sheath, or cardiac tissue) or positive findings on technetium-99m pyrophosphate (Tc-99m-PYP) scintigraphy with single-photon emission computed tomography (SPECT) scanning

☐ **Hereditary ATTR-CM consists of ALL of the following:**
- ☐ Presence of a variant TTR genotype associated with CM and presenting with a CM phenotype
- ☐ Evidence of cardiac involvement by echocardiography with end-diastolic interventricular septal wall thickness greater than 12 mm
- ☐ Presence of amyloid deposits in biopsy tissue (fat aspirate, salivary gland, median nerve connective tissue sheath, or cardiac tissue) or positive findings on Tc-99m-PYP scintigraphy with SPECT scanning

RENEWAL REQUEST

Discontinuation Criteria:

1.) Is the patient experiencing NYHA class IV heart failure? ☐ Yes ☐ No
2.) Has the patient received an implanted CMAD? ☐ Yes ☐ No
3.) Has the patient received a heart or liver transplant? ☐ Yes ☐ No

PRESCRIBER NAME & ADDRESS:

_____ **LICENCE #**

_____ **PRESCRIBER SIGNATURE**

_____ **DATE**

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1
Fax: (902) 496-4440

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