



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Vyndamax™ (tafamidis)

**Review Criteria**

Member must meet all the following criteria:

- Member must have a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) required
- Biopsy or cardiac magnetic resonance imaging report must be provided supporting diagnosis
- Member must be exhibiting clinical symptoms of cardiomyopathy and heart failure (i.e., dyspnea, fatigue, orthostatic hypotension, syncope, angina, peripheral edema)
- Initial authorization granted for one year
- Yearly renewals require verbal attestation from provider that member has had a positive clinical response to treatment

Limitations:

- Maximum daily dose approved is 61mg