Authorization Request Form - Part 2

Tc-pyrophosphate Scan

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely ⬭ → ⬬

Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Cardiomyopathies**

Question 1

Does the patient have any of the following?

- ☐ Unexplained left ventricular hypertrophy (LVH).
- ☐ Aortic stenosis and features of cardiac amyloidosis.
- ☐ Signs or symptoms typical of amyloidosis.
- ☐ Suspicion of cardiac ATTR amyloidosis, and the patient has a contraindication to magnetic resonance (e.g., renal insufficiency, presence of a pacemaker).
- ☐ The patient has monoclonal protein identified by serum or urine protein electrophoresis.
- ☐ None of the above