Manitoba

Onpattro (Patisiran Sodium) / Amvuttra (Vutrisiran)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	
Type of Request: ◯ New Request (Duration of approval: 10 months) ◯ 1st Renewal (Duration of approval: 6 months) ◯ 2nd and subsequent renewals (Duration of approval: 1 year)	**Medication Requested:** ◯ Onpattro (Patisiran Sodium) ◯ Amvuttra (Vutrisiran)	
Strength and Dosage Form	**Regimen:**	

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

For INITIAL Requests:			
Indication:	◯ For the treatment of polyneuropathy in patients with hereditary transthyretin-mediated amyloidosis (hATTR)		
	◯ Other: _____		
Please select YES or NO to the following statements:			
The patient is 18 years of age or older.		◯ YES	◯ NO
The patient has a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis.		◯ YES	◯ NO
A copy of the laboratory documentation for the genetic mutation for ATTR is attached with this application **(required).**		◯ YES	◯ NO
The patient is under the care of a specialist with experience in the diagnosis and management of hATTR.		◯ YES	◯ NO
Please specify whether the patient meets the following exclusion criteria:			
The patient is pre-symptomatic.		◯ YES	◯ NO
The patient is diagnosed with severe heart failure (defined as New York Heart Association [NYHA] class III or IV).		◯ YES	◯ NO
The patient is a recipient of a liver transplant.		◯ YES	◯ NO
The requested medication will be used in combination with other interfering ribonucleic acid drugs (patisiran sodium, vutrisiran), transthyretin stabilizers (tafamidis), or diflunisal for the treatment of hATTR.		◯ YES	◯ NO
Please specify the signs and symptoms of polyneuropathy the patient is currently experiencing:			

Updated February 3, 2026

Please provide the staging score for ONE of the following:

Familial Amyloid Polyneuropathy (FAP) stage: Clinical staging system for the neuropathy symptoms of hATTR (formerly termed familial amyloid neuropathy).

- ☐ *FAP Stage 1: Walking without assistance, mild neuropathy (sensory, autonomic, and motor) in lower limbs*
- ☐ *FAP Stage 2: Walking with assistance, moderate impairment in lower limbs, trunk, and upper limbs*
- ☐ *FAP Stage 3: wheelchair or bed-ridden, severe neuropathy*

Polyneuropathy disability score (PND): A five-stage measure of neuropathy impairment ranging from 0 (no impairment) to 4 (confined to a wheelchair or bedridden).

- ☐ *Stage 0: no impairment*
- ☐ *Stage I: sensory disturbances but preserved walking capability*
- ☐ *Stage II: impaired walking capability but ability to walk without a stick or crutches*
- ☐ *Stage IIIA: walking only with the help of one stick or crutch*
- ☐ *Stage IIIB: walking with the help of two sticks or crutches*
- ☐ *Stage IV: confined to a wheelchair or bedridden*

Additional Relevant Clinical Information:

For RENEWAL Requests:		
The patient is permanently bedridden and dependent on assistance for basic activities of daily living.	◯ YES	◯ NO
The patient is receiving end-of-life/palliative care where survival of less than one year is expected.	◯ YES	◯ NO

Prescriber Signature and Date:

Please check the following:

☐ I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage.

Date:	Prescriber Signature: