

Amyloidosis Therapies
Wainua (eplontersen)
Effective 10/01/2026

Plan	☒ MassHealth UPPL ☐ Commercial/Exchange		Program Type	☒ Prior Authorization
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit			☐ Quantity Limit ☐ Step Therapy
Specialty Limitations	N/A			
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029	
Notes	This medication is also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.			

Overview

Wainua (eplontersen) is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted when all of the following criteria are met:

1. Diagnosis of polyneuropathy of hATTR (hereditary transthyretin-mediated amyloidosis) amyloidosis (similar to ATTRv, or variant transthyretin-mediated amyloidosis)
2. Member is ≥ 18 years of age
3. Prescriber is a rheumatologist or neurologist or consult notes from a rheumatologist or neurologist are provided
4. Results from genetic testing showing mutations in the TTR gene
5. For Wainua, inadequate response or adverse reaction to ONE or contraindication to BOTH of the following:
 - a. Amvuttra (vutrisiran)
 - b. Onpattro (patisiran)
6. Baseline polyneuropathy disability (PND) score of I, II, IIIa, or IIIb
7. Appropriate dosing

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. Prescriber must provide documentation of positive response to therapy

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 6 months

References

1. Wainua® [package insert] Wilmington (DE): AstraZeneca Pharmaceuticals LP; 2025 Apr
2. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013; 8:31.
3. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013;8:31.
4. Hawkins PN, Ando Y, Dispenzeri A, et al. Evolving landscape in the management of transthyretin amyloidosis. Ann Med. 2015;47(8):625-38.

Review History

9/9/26 – Created for P&T. Wainua was added to MB requiring PA and will also be available on PB with PA (dual). Criteria is aligned with MHDL. Effective 10/1/26

