

EXONDYS 51 (eteplirsen) PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Exondys 51** accessible on the Department’s Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact’s phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication: Exondys 51	Quantity: <input type="checkbox"/> _____ 100 mg/2 ml vials <input type="checkbox"/> _____ 500 mg/10 ml vials	Refills:
Directions: <input type="checkbox"/> _____ mg once weekly <input type="checkbox"/> other: _____		
Diagnosis:	Dx code (required):	Weight: _____ lbs / kg

INITIAL REQUESTS

1. Does the recipient have a diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping?	<input type="checkbox"/> Yes – <i>submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>submit medical literature supporting the use of Exondys 51 for the recipient’s diagnosis.</i>
2. Is Exondys 51 prescribed by or in consultation with a neurologist with experience treating DMD?	<input type="checkbox"/> Yes <i>Submit documentation of consultation with specialist, if applicable.</i> <input type="checkbox"/> No
3. Did the recipient have a baseline evaluation, including a standardized assessment of motor function, by a neurologist with experience treating DMD?	<input type="checkbox"/> Yes <i>Submit documentation of baseline evaluation and assessment.</i> <input type="checkbox"/> No
4. Will the recipient be taking corticosteroids in addition to Exondys 51?	<input type="checkbox"/> Yes <i>Submit documentation of planned medication regimen.</i> <input type="checkbox"/> No
5. Does the recipient have a contraindication or intolerance to corticosteroids?	<input type="checkbox"/> Yes <i>Submit documentation of all contraindications/intolerances.</i> <input type="checkbox"/> No

RENEWAL REQUESTS

1. Is Exondys 51 prescribed by or in consultation with a neurologist with experience treating Duchenne muscular dystrophy (DMD)?	<input type="checkbox"/> Yes <i>Submit documentation of consultation with specialist, if applicable.</i> <input type="checkbox"/> No
2. Did the recipient have an annual evaluation, including a standardized assessment of motor function, by a neurologist with experience treating DMD?	<input type="checkbox"/> Yes <i>Submit documentation of annual evaluation and assessment.</i> <input type="checkbox"/> No
3. Is the recipient experiencing clinical benefit from Exondys 51?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
4. Will the recipient be taking corticosteroids in addition to Exondys 51?	<input type="checkbox"/> Yes <i>Submit documentation of medication regimen.</i> <input type="checkbox"/> No
5. Does the recipient have a contraindication or intolerance to corticosteroids?	<input type="checkbox"/> Yes <i>Submit documentation of all contraindications/intolerances.</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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