OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

DRUG REQUESTED: Exondys 51™ (eteplirsen) **IV (J1428/C9484) (Medical)**

DRUG INFORMATION: Complete all information below. Medical notes and lab values **MUST** be submitted with this request form or authorization process could be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Medical notes MUST be submitted with this request to support each line checked.

RECOMMENDED DOSING: 30 mg per kilogram administered once weekly as a 35 to 60 minute intravenous infusion

CLINICAL CRITERIA: **All** boxes that apply **MUST** be checked to qualify. Incomplete information or medical notes, laboratory values, etc. **not** attached with this form request will delay the authorization process**.**

Initial Approval: Length of approval is for 6 months

- ❑ Prescriber is or in consultation with: **Pediatric Neurologist**
- ❑ Patient diagnosed with Duchenne muscular dystrophy (DMD)
- ❑ Provider **MUST** submit medical records **(e.g., chart notes, lab values)** confirming the mutation of the DMD gene is amenable to Exon 51 skipping
- ❑ Patient is ≥ 7 years of age
- ❑ Patient not taking Exondys 51™ with any other RNA antisense agent (e.g., drisapersen) or any other gene therapy
- ❑ Exondys 51™ dosing for DMD **MUST** be in accordance with the United States Food and Drug Administration approved labeling; max dosing of 30 mg/kg once weekly.
- ❑ Must have a trial of **one** of the following for **at least 52 weeks** with failure to maintain ambulation:

❑ deflazacort	❑ prednisone	❑ prednisolone

- ❑ 6-minute walking test baseline value of: _____ (**must be submitted)**
- ❑ Dystrophin level baseline: _____ **(must be submitted)**

(continued on next page)

Reauthorization Approval: Length of approval is for 6 months

- Documentation supports positive response to therapy **(must meet all of the following)**:
- Increase in dystrophin level
- Improved 6-minute walking test
- Improvement in respiratory or muscle strength

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**: **PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

UPDATED: ~~4/6/2018; 8/20/2018;~~ **10/8/2018**