

# OPTIMA HEALTH COMMUNITY 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  $\geq 7$  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)

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**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; (Reformatted) 2/5/2019