

OPTIMA HEALTH COMMUNITY CARE

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 51TM (eteplirsen) IV (J1428/C9484) (Medical) **MEDICAID ONLY**

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 51TM with any other RNA antisense agent (e.g., drisapersen) or any other gene therapy
- Exondys 51TM 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**)

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

(signature on next page)

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