

# 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 51<sup>TM</sup> (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  $\geq 7$  years of age
- Patient not taking Exondys 51<sup>TM</sup> with any other RNA antisense agent (e.g., drisapersen) or any other gene therapy
- Exondys 51<sup>TM</sup> 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)

