OPTIMA HEALTH PLAN

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 1-844-723-2094. 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)*** ***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 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)***

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 #: _____

***Approved by the Pharmacy and Therapeutic Committee**: 10/19/2017
UPDATED: 12/18/2017