carolina complete health

Request for Prior Approval Exondys 51

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information - Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested: **EXONDYS 51** 9a. Strength: _____9b. Quantity per 30 days _____

9c. Requested Duration (up to 6 months) _____ 9d. Beneficiary's weight _____

10. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy? **YES**____**NO**____

11. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 51 skipping? **YES**____**NO**____

12. Is Exondys 51 being prescribed by or in consultation with a neurologist? **YES**____**NO**____

13. Is the beneficiary taking any other RNA antisense agent or any other gene therapy?

YES____**NO**____

14. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week?

YES____**NO**____

For PA renewal

15. Is documentation attached that shows the beneficiary:

a. Has shown an improvement in dystrophin levels **or**

b. Is not ventilator dependent **or**

c. Has some functional use of upper extremities **or**

d. Has an ability to walk with or without assistive devices

YES____**NO**____

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309