carolina complete health™

Pharmacy Prior Approval Request for Exondys 51

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For initial authorization requests:
1. What is the beneficiary's weight? _____
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy? ☐ **Yes** ☐ **No**
3. 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**
4. Is Exondys 51 being prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**
5. Is the beneficiary taking any other RNA antisense agent or any other gene therapy? ☐ **Yes** ☐ **No**
6. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week? ☐ **Yes** ☐ **No**

For reauthorization:
7. Please attach documentation that shows the beneficiary:
   - ☐ Has shown an improvement in dystrophin levels **or**
   - ☐ Is not ventilator dependent **or**
   - ☐ Has some functional use of upper extremities **or**
   - ☐ Has an ability to walk with or without assistive devices

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.