https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

ETEPLIRSEN (EXONDYS 51)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: ____________________	Prescribing Physician: ____________________
Patient ID #: ____________________	Physician Address: ____________________
Patient DOB: ____________________	Physician Phone #: ____________________
Date of Rx: ____________________	Physician Fax #: ____________________
Patient Phone #: ____________________	Physician Specialty: ____________________
Patient Email Address: ____________________	Physician DEA: ____________________
	Physician NPI #: ____________________
	Physician Email Address: ____________________

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
	____________	____________________	Specify: ____________

7. DIAGNOSIS (attach results of genetic testing):
Patient's weight (kg): _Date obtained_
Please indicate setting in which Exondys is to be administered:
____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for Exondys 51 (eteplirsen). Payment will be considered for patients when the following criteria are met:

Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with mutation amenable to exon 51 skipping confirmed by genetic testing (attach results of genetic testing); and 2) Is prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy; and 3) Patient is currently ambulatory; and 4) A baseline 6-Minute Walk Distance (6MWD) is provided and patient is able to achieve a distance of at least 180 meters while walking independently; and 5) Patient is currently stable on an oral corticosteroid regimen for at least 6 months; and 6) Is dosed based on FDA approved dosing: 30 mg/kg once weekly; and 7) Medication is to be administered by a healthcare professional in member's home by home health or in a long-term care facility. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. When criteria for coverage are met, an initial authorization will be given for 6 months. Requests for continuation of therapy will be considered at 6 month intervals when the following criteria are met: 1) Patient has demonstrated a response to therapy as evidenced by remaining ambulatory (able to walk with or without assistance, not wheelchair dependent); and 2) An updated 6MWD is provided documenting patient is able to achieve a distance of at least 180 meters.

Initial Requests

Does Prescriber specialize in treatment of DMD? ☐ Yes ☐ No If no, note consultation with Specialist:

Consultation date:_________ Physician name & phone: ______________________________

https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

ETEPLIRSEN (EXONDYS 51)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 1-844-512-9004

PATIENT NAME:____________________________________**PATIENT ID #:** __________________________

Is patient ambulatory (able to walk with or without assistance, not wheelchair bound)? ☐ Yes ☐ No

Result of baseline 6MWD (in meters): _______**Date completed**:_____________

Is patient currently stable on an oral corticosteroid regimen for at least 6 months? ☐ No ☐ Yes (document below)

Oral corticosteroid trial: Drug name:________________________________Strength:_________________________

Renewal Requests

Does patient remain ambulatory (able to walk with or without assistance, not wheelchair bound)? ☐ Yes ☐ No

Result of subsequent 6MWD (in meters): __________**Date completed**:_____________

9. PHYSICIAN SIGNATURE

____ ______________________________

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.