Request for Prior Authorization: Muscular Dystrophy Agents

Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Contains confidential patient information

Instructions

Complete form in its entirety and fax to the Prior Authorization of Benefits Center at **844-864-7860** (retail) or **888-209-7838** (medical injectable).

Care provider help lines:

- **866-408-6132** Hoosier Healthwise
- **844-533-1995** Healthy Indiana Plan
- **844-284-1798** Hoosier Care Connect
- **833-569-4739** Indiana PathWays for Aging

Today's date

Month	Day	Year

Note: This form must be completed by the prescribing provider.

All sections must be completed, or the request will be returned.

Patient

Patient's Medicaid No.	
Patient's name	
Patient's DOB	

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Prescriber

Prescriber's name		**Specialty**	
Prescriber's Indiana license No.			
Prescriber's NPI No.			
Prescriber's signature			
Return fax No.		**Return phone No.**	
Select if requesting retroactive prior authorization (PA)	☐ Retroactive PA	**Date(s) of service requested for retroactive eligibility (if applicable)**	

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested medication

Requested medication	Quantity	Requested dose and frequency

Agamree (vamorolone) PA requirements

☐ Member is ≥ 2 years of age.

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation).

Member has had previous trial-and-failure history of at least 90 days of therapy with Emflaza (deflazacort) ☐ Yes ☐ No

Dates of trial
Start date:
Stop date:

If you selected no, provide medical justification for use of Agamree (vamorolone) over Emflaza (deflazacort):

☐ Prescriber has conducted testing to determine current clinical status and submitted with PA request (for example, Brooke Score, six-minute walk test, pulmonary function tests)

Member weight: <Enter>
Note: Dose will be approved for 6mg/kg/day (max: 300 mg/day or two bottles every 25 days), rounded to the nearest tenth of a milliliter of oral suspension.

Duvyzat (givinostat) PA requirements

☐ Member is ≥ 6 years of age.

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation).

Member has had previous trial-and-failure history of at least 90 days of therapy with **either** Agamree (vamorolone) **or** Emflaza (deflazacort) as single agent therapy. ☐ Yes ☐ No

Medication name:
Dates of trial
Start date:
Stop date:

If you selected no, provide medical justification for use of Duvyzat (givinostat) over **both** Agamree (vamorolone) **and** Emflaza (deflazacort):

☐ Prescriber attests to all the following:

- Member is ambulatory prior to initiation of therapy. ☐ Yes ☐ No
- Prescriber has obtained baseline platelet count and triglycerides prior to initiating therapy. ☐ Yes ☐ No
- Baseline platelet count is 150 x 10^9 L or greater. ☐ Yes ☐ No
- Prescriber will continue to monitor platelet count and triglycerides and adjust dosing per the prescribing information. ☐ Yes ☐ No

I, _____ hereby attest that member qualifies for initiation of therapy based on the criteria above.

Prescriber signature: _____

Note: Dose will be approved for up to 53.2 mg twice daily (three bottles/35 days.

For reauthorization only

☐ Prescriber has submitted documentation (such as current and previous chart notes) explicitly supporting improvement (including disease stabilization) in current clinical status (for example, four-stair climb time, North Star Ambulatory Assessment (NSAA), six-minute walk test).

Emflaza (deflazacort) PA requirements

☐ Member is ≥ 2 years of age.

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation).

☐ Prescriber has conducted testing to determine current clinical status and submitted with PA request (for example, Brooke Score, six-minute walk test, pulmonary function tests).

Member weight: <Enter>

Note: Dose will be approved for 0.9 mg/kg/day rounded to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension.

Other drugs

Amondys 45, Exondys 51, Viltepso, and Vyondys 53 are state carve-out drugs. For those drugs, utilize the muscular dystrophy agents prior authorization form on the FFS website.

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