

Prior Authorization Form: Antisense oligonucleotides for Duchenne muscular dystrophy

HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed.

Please use one form per member.

Member information

Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Weight in kilograms: _____

Prescriber information

Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Drug information

For initial requests, continue below. For renewal requests, proceed to page [three] of this form.

Drug name: _____ Drug form: _____

Drug strength: _____ Dosing frequency: _____

Length of therapy: _____ Quantity: _____

Day supply: _____

(Form continued on next page.)

Member last name:

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Member first name:

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Diagnosis and medical information

If the physician does not have the necessary information, the request will be denied and the fax form requesting additional information will be sent to the prescriber.

Initial coverage for all medications will be limited to the following:

1. Does the member have a confirmed diagnosis of Duchenne muscular dystrophy (DMD) with [one] of the following? **And**
 - For Amondys 45TM: A confirmed mutation of the DMD gene that is amendable to exon 45 skipping **or**
 - For Exondys 51TM: A confirmed mutation of the DMD gene that is amendable to exon 51 skipping **or**
 - For Vyondys 53TM or Viltepso[®]: A confirmed mutation of the DMD gene that is amendable to exon 53 skipping
2. Has the member been on a stable dose of corticosteroids unless there is a contraindication or intolerance?
And
 - Yes No
3. Will the requested agent be used as the only exon skipping therapy for the member's DMD?
 - Yes No

(Form continued on next page.)

Member last name:

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Member first name:

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Renewal coverage for all medications will be limited to the following:

1. Does the member continue to meet the initial criteria? **And**

Yes No

2. Does the member have an absence of unacceptable toxicity to the drug? **And**

Yes No

3. Is the member being appropriately monitored for a beneficial response to therapy?

Yes No

Attachments

Prescriber signature (required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include all requested information. Incomplete forms will delay the PA process.
Submission of documentation does **not** guarantee coverage by.

The completed form may be **faxed to 844-512-7020**.