

# SENTARA COMMUNITY PLAN (MEDICAID)

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

### Duchenne Muscular Dystrophy Drugs (Pharmacy)

**Drug Requested:** (Check box below that applies)

PREFERRED		
<input type="checkbox"/> Emflaza®		
Non-Preferred		
<input type="checkbox"/> Agamree®	<input type="checkbox"/> Amondys-45™	<input type="checkbox"/> deflazacort
<input type="checkbox"/> Duvyzat™	<input type="checkbox"/> Exondys-51™	<input type="checkbox"/> Jaythari
<input type="checkbox"/> Pyquvi™	<input type="checkbox"/> Viltepso®	<input type="checkbox"/> Vyondys-53™

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member Sentara #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

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**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Length of Authorization: 1 year**

- ☐ Member must have a confirmed diagnosis of Duchenne Muscular Dystrophy (DMD)
- ☐ For Amondys-45<sup>TM</sup>, Exondys-51<sup>TM</sup>, Viltepso<sup>®</sup> or Vyondys-53<sup>TM</sup>:
  - ☐ Member has been on a stable dose of corticosteroids unless there is a contraindication or intolerance
  - ☐ The requested agent will be used as the only exon skipping therapy for the member's DMD
  - ☐ For **Amondys-45<sup>TM</sup>**: A confirmed mutation of the DMD gene that is amendable to exon 45 skipping
  - ☐ For **Exondys-51<sup>TM</sup>**: A confirmed mutation of the DMD gene that is amendable to exon 51 skipping
  - ☐ For **Vyondys-53<sup>TM</sup>** or **Viltepso<sup>®</sup>**: A confirmed mutation of the DMD gene that is amendable to exon 53 skipping
- ☐ For **Agamree<sup>®</sup>** and **deflazacort**:
  - ☐ Member is 2 years of age or older
  - ☐ Member has tried and failed or is intolerant to prednisone or prednisolone
  - ☐ Member has tried and failed or is intolerant to brand Emflaza<sup>®</sup>
- ☐ For **Duvyzat<sup>TM</sup>**:
  - ☐ Member is 6 years of age or older
  - ☐ Member has tried and failed or is intolerant to prednisone or prednisolone
  - ☐ Member has tried and failed or is intolerant to brand Emflaza<sup>®</sup>
- ☐ For **Emflaza<sup>®</sup>**:
  - ☐ Member is 2 years of age or older
  - ☐ Member has tried and failed or is intolerant to prednisone or prednisolone
- ☐ For **Jaythari** and **Pyquvi<sup>TM</sup>**:
  - ☐ Member is 5 year of age or older
  - ☐ Member has tried and failed or is intolerant to prednisone or prednisolone
  - ☐ Member has tried and failed or is intolerant to brand Emflaza<sup>®</sup>

**Reauthorization: 1 year.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member continues to meet the initial criteria
- ☐ Member has an absence of unacceptable toxicity to the drug
- ☐ Member is being appropriately monitored for a beneficial response to therapy

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Medication being provided by Specialty Pharmacy - PropriumRx

*\*Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.\**

*\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*