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		
❑ **Emflaza®**		
Non-Preferred		
❑ **Agamree®**	❑ **Amondys-45™**	❑ **deflazacort**
❑ **Duvyzat™**	❑ **Exondys-51™**	❑ **Jaythari**
❑ **Kymbee™**	❑ **Pyquvi™**	❑ **Viltepso®**
❑ **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™, Exondys-51™, Viltepso® or Vyondys-53™:
  - ❑ 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™**: A confirmed mutation of the DMD gene that is amendable to exon 45 skipping
  - ❑ For **Exondys-51™**: A confirmed mutation of the DMD gene that is amendable to exon 51 skipping
  - ❑ For **Vyondys-53™** or **Viltepso®**: A confirmed mutation of the DMD gene that is amendable to exon 53 skipping
- ❑ For **Agamree®** 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®
- ❑ For **Duvyzat™:**
  - ❑ 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®
- ❑ For **Emflaza®**:
  - ❑ Member is 2 years of age or older
  - ❑ Member has tried and failed or is intolerant to prednisone or prednisolone
- ❑ For **Kymbee™**, **Jaythari** and **Pyquvi™:**
  - ❑ 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®

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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

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.

UPDATED/REVISED/REFORMATTED: ~~6/29/2017; 8/29/2017; 8/18/2018; 1/14/2020; 6/18/2020; 11/3/2023; 8/14/2024, 12/13/2024, 9/10/2025; 10/20/2025;~~ **9/21/2026**