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**
❑ **Exondys-51™**	❑ **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:** _____

(Continued on next page)

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™**: 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®**:
  - ❑ 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 Emflaza®
- ❑ For **Emflaza®** and **deflazacort**:
  - ❑ Member is 2 years of age or older
  - ❑ Member has tried and failed or is intolerant to prednisone or prednisolone
  - ❑ If requesting generic deflazacort, member has tried and failed preferred brand Emflaza®
- ❑ 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

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 be provided by a 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.