# 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 (Medical)

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

| | |
|---|---|
| ❑ **Amondys 45™** (casimersen) **IV (J1426)** | ❑ **Exondys 51™** (eteplirsen) **IV (J1428/C9484)** |
| ❑ **Viltepso®** (viltolarsen) **IV (J1427)** | ❑ **Vyondys 53™** (golodirsen) **IV (J1429)** |

**Recommended Dosing:**

| Medication | Indication | Dosing Limits |
|---|---|---|
| Exondys 51™ (eteplirsen) | DMD with a confirmed mutation of the DMD gene that is amenable to exon 51 skipping | 30 mg/kg IV once weekly |
| Vyondys 53™ (golodirsen) | DMD with a confirmed mutation of the DMD gene that is amenable to exon 53 skipping | 30 mg/kg IV once weekly |
| Viltepso® (viltolarsen) | DMD with a confirmed mutation of the DMD gene that is amenable to exon 53 skipping | 80 mg/kg IV once weekly |
| Amondys 45™ (casimersen) | DMD with a confirmed mutation of the DMD gene that is amenable to exon 45 skipping | 30 mg/kg IV once weekly |

**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 #:** _____

**(Continued on next page)**

**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:** _____

**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 **Amondys-45™**, **Exondys-51™**, **Viltepso®** or **Vyondys-53™**:
  - ❑ Member has been on a stable dose of corticosteroids unless there is a contraindication or intolerance
  - ❑ Member has tried and failed or is intolerant to Emflaza®
  - ❑ 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.***