SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization 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:** _____

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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
  - ❑ 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.