peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Eteplirsen (Exondys 51)
Prior Authorization Form/Prescription

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other: _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Secure Fax #:	Office Contact:	

Primary Diagnosis

ICD-10 Code: _____

☐ Duchenne muscular dystrophy (DMD) ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Exondys 51 (eteplirsen)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

1. Has patient had a positive response to the prescribed therapy within the last 30 days?
   ☐ Yes **Mark all that apply** ☐ No ☐ Not applicable
   a. Ambulatory function with a 6 minute walk test distance (6MWT) ≥ 200m? ☐ Yes: _____ m Date: _____ ☐ No
   b. Stable cardiac function with left ventricular ejection fraction (LVEF) > 40%? ☐ Yes: _____ % Date: _____ ☐ No
   c. Stable pulmonary function with predicted forced vital capacity (FCV) ≥ 50%? ☐ Yes: _____ % Date: _____ ☐ No
   d. Other: _____
2. Is Exondys 51 prescribed concurrently with an oral corticosteroid?
   ☐ Yes: _____ ☐ No ☐ No, contraindicated/intolerant
3. Is Exondys 51 prescribed concurrently with other exon-skipping therapies (e.g., Vyondys 53)? ☐ Yes: _____ ☐ No

Complete this section ONLY if the patient is <u>initiating</u> therapy OR if the patient is <u>new</u> to this health plan:

4. Is therapy prescribed by or in consultation with a neurologist? ☐ Yes ☐ No
5. **If DMD**, is mutation amenable to exon 51 skipping confirmed with genetic testing? ☐ Yes, mutation: _____ - _____ ☐ No
6. Has the patient had an inadequate response (evidenced by significant decline in 6MWT, LVEF, OR FVC) despite adherent use of an oral corticosteroid (e.g., prednisone, Emflaza) for ≥ 6 months? ☐ Yes ☐ No ☐ No, contraindicated/intolerant

Complete this section ONLY for indications <u>other</u> than DMD:

7. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Please continue to page 2

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Patient Name: _____ **DOB:** _____

Physician's Signature: _____ **Date:** _____ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

Authorization Information

Authorization number:	**Decision Due Date:**
J-Code:	**Coverage:** ☐ State excludes ☐ COB (secondary)
Line of Business: ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare (CY2019/20 Carved out)	**Benefit:** ❑ Medical ❑ Pharmacy

Criteria:
❑ Centene Policy
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

Medicare only criteria for CY2019 and CY2020: Carved out to FFS (Fee for service) Medicare