

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: <input type="checkbox"/> Male <input type="checkbox"/> 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
Vyondys 53 (golodirsén)				

**Clinical Information**

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

INITIAL THERAPY  CONTINUATION OF THERAPY; Therapy start date: \_\_\_\_\_

- Has patient had a positive response to the prescribed therapy within the last 30 days?  
 Yes **\*\*Mark all that apply\*\***  No  Not applicable
  - Ambulatory function with a 6 minute walk test distance (6MWT)  $\geq$  250 m?  Yes: \_\_\_\_\_ m Date: \_\_\_\_\_  No
  - Stable cardiac function with left ventricular ejection fraction (LVEF)  $>$  50%?  Yes: \_\_\_\_\_ % Date: \_\_\_\_\_  No
  - Stable pulmonary function with predicted forced vital capacity (FVC)  $\geq$  50%?  Yes: \_\_\_\_\_ % Date: \_\_\_\_\_  No
  - Other: \_\_\_\_\_
- Is Vyondys 53 prescribed concurrently with an oral corticosteroid?  
 Yes: \_\_\_\_\_  No  No, contraindicated/intolerant
- Is Vyondys 53 prescribed concurrently with other exon-skipping therapies (e.g. Exondys 51)?  Yes  No

**Complete this section ONLY if the patient is initiating therapy OR if the patient is new to this health plan:**

- Is therapy prescribed by or in consultation with a neurologist?  Yes  No
- If DMD, is mutation amenable to exon 53 skipping confirmed with genetic testing?  Yes, mutation: \_\_\_\_\_ - \_\_\_\_\_  No
- Has the patient had an inadequate response (evidence by significant decline in 6MWT, LVEF, or FVC) despite adherent use of an oral corticosteroid (e.g., prednisone, Emflaza™) for  $\geq$  6 months?  Yes  No  No, contraindicated/intolerant

**Complete this section ONLY for indications other than DMD:**

- Has patient tried and failed, or is contraindicated to, accepted standards of care?  Yes  No  
**\*\*If yes, submit documentation and answer the following:\*\***
  - Please list all previous therapies: \_\_\_\_\_
  - Was patient adherent to previously tried therapies?  Yes  No  No, patient intolerant to drug

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  DAW

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

**Golodirsen (Vyondys 53)**

**Prior Authorization Form/Prescription**

Date: \_\_\_\_\_ Date Medication Required: \_\_\_\_\_  
Ship to:  Physician  Patient's Home  Other \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

**Authorization Information**

<b>Authorization number:</b>	<b>Decision Due Date:</b>
<b>J-Code:</b>	<b>Coverage:</b> <input type="checkbox"/> State excludes <input type="checkbox"/> COB (secondary)
<b>Line of Business:</b> <input type="checkbox"/> Commercial <input type="checkbox"/> Health Insurance Marketplace <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<b>Benefit:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy
<b>Criteria:</b> <input type="checkbox"/> Centene Policy Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____ <input type="checkbox"/> State Specific (please include policy)	
<b>Medicare only criteria for CY2019 and CY2020:</b> <input type="checkbox"/> PART B use LCD or NCD <input type="checkbox"/> PART D use the Medicare Part D Vyondys 53 specific criteria	