peach state health plan

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 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
Vyondys 53 (golodirsen)				

Clinical Information

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

* **THERAPY TYPE (choose one):** ☐ INITIAL THERAPY ☐ CONTINUATION OF THERAPY - Therapy start date: _____

1. Has patient had a positive response to the prescribed therapy within the last 6 months?
   ☐ Yes ***Mark all that apply*** ☐ No ☐ Not applicable
   ☐ Ambulatory function with a 6 minute walk test distance (6MWT) ≥ 250 m: _____ m Date: _____
   ☐ Stable cardiac function with left ventricular ejection fraction (LVEF) > 50%: _____ % Date: _____
   ☐ Stable pulmonary function with predicted forced vital capacity (FVC) ≥ 50%: _____ % Date: _____
   ☐ Patient has received medication via healthcare insurer and medical record shows improved, or stable, LVEF and FVC assessed within the last 6 months:
   Baseline LVEF: _____ %, Date: _____ Current LVEF: _____ % Date: _____
   Baseline FVC: _____ % Date: _____ Current FVC: _____ % Date: _____
   ☐ Other: _____
2. Has patient been assessed by a neurologist within the last 6 months? ☐ Yes ☐ No
3. Is Vyondys 53 prescribed concurrently with an oral corticosteroid?
   ☐ Yes: _____ ☐ No ☐ No, contraindicated/intolerant
4. Is Vyondys 53 prescribed concurrently with other exon-skipping therapies (e.g. Amondys 45, Exondys 51, Viltepso)? ☐ Yes ☐ No
5. Is mutation amenable to exon 53 skipping confirmed with genetic testing? ☐ Yes, mutation: _____ - _____ ☐ No
6. Please document patient's weight: _____ kg

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

7. Is therapy prescribed by or in consultation with a neurologist? ☐ Yes ☐ No
8. 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 ≥ 6 months? ☐ Yes ☐ No ☐ No, contraindicated/intolerant

Please continue to page 2

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Patient Name: _____ **DOB:** _____

9. Has patient had an assessment of all of the following within the last 30 days?
   ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Ambulatory function with a 6 minute walk test distance (6MWT) ≥ 250 m: _____ m Date: _____
   ☐ Stable cardiac function with left ventricular ejection fraction (LVEF) > 50%: _____ % Date: _____
   ☐ Stable pulmonary function with predicted forced vital capacity (FVC) ≥ 50%: _____ % Date: _____

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

10. 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

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	***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)