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* *****

☐ **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) ≥ 250 m? ☐ Yes: ________ m ☐ No
   b. Stable cardiac function with left ventricular ejection fraction (LVEF) > 50%? ☐ Yes: : ________ % ☐ No
   c. Stable pulmonary function with predicted forced vital capacity (FVC) ≥ 50%? ☐ Yes : ________ % ☐ No
   d. Other: ____
2. Is Vyondys 53 prescribed concurrently with an oral corticosteroid? ☐ Yes ☐ No ☐ No, contraindicated/intolerant to both
3. Is Vyondys 53 prescribed concurrently with other exon-skipping therapies (e.g. Exondys 51)? ☐ 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 53 skipping confirmed with genetic testing? ☐ Yes, mutation: _________ - _________ ☐ No
6. 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

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

Physician's Signature: ______________________________________ **Date:** ____________________ ☐ DAW

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Patient Name: ____ **DOB:** ______________________

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)

Medicare only criteria for CY2019 and CY2020:
❑ PART B use LCD or NCD ❑ PART D use the Medicare Part D Vyondys 53 specific criteria