peach state health plan

# Viltolarsen (Viltepso)

## Prior Authorization Form/Prescription

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

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 |
|---|---|---|---|---|
| Viltepso (viltolarsen) | | | | |

## 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 30 days?
   ☐ Yes **Mark all that apply** ☐ No ☐ Not applicable
   ☐ Ambulatory function with a 6 minute walk test distance (6MWT) ≥ 201 m: _____ m Date: _____
   ☐ Ambulatory function with a time-to-stand (TTSTAND) < 10 seconds: _____ seconds Date: _____
   ☐ Stable cardiac function with left ventricular ejection fraction (LVEF) ≥ 40%: _____ % 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 Viltepso prescribed concurrently with an oral corticosteroid? ☐ Yes ☐ No ☐ No, contraindicated/intolerant
4. Is Viltepso prescribed concurrently with other exon-skipping therapies (e.g. Amondys 45, Exondys 51, Vyondys 53)? ☐ 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, TTSTAND, LVEF, or FVC) despite adherent use of an oral corticosteroid (e.g., prednisone, Emflaza™) for ≥ 6 months? ☐ Yes ☐ No ☐ No, contraindicated/intolerant

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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) ≥ 201 m: _____ m Date: _____
   ☐ Ambulatory function with a time-to-stand (TTSTAND) < 10 seconds: _____ seconds Date: _____
   ☐ Stable cardiac function with left ventricular ejection fraction (LVEF) ≥ 40%: _____ % 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:**<br>❑ State excludes ❑ COB (secondary) |
| ***Line of Business:**<br>❑ Commercial ❑ Health Insurance Marketplace<br>❑ Medicaid ❑ Medicare | ***Benefit:**<br>❑ 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)