Iowa Department of Human Services

Request for Prior Authorization ETEPLIRSEN (EXONDYS 51)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Exondys 51 (eteplirsen). Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with mutation amenable to exon 51 skipping confirmed by genetic testing (attach results of genetic testing); and 2) Is prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy; and 3) Patient is currently ambulatory; and 4) A baseline 6-Minute Walk Distance (6MWD) is provided and patient is able to achieve a distance of at least 180 meters while walking independently; and 5) Patient is currently stable on an oral corticosteroid regimen for at least 6 months; and 6) Is dosed based on FDA approved dosing: 30 mg/kg once weekly; and 7) Medication is to be administered by a healthcare professional in member's home by home health or in a long-term care facility. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. When criteria for coverage are met, an initial authorization will be given for 6 months. Requests for continuation of therapy will be considered at 6 month intervals when the following criteria are met: 1) Patient has demonstrated a response to therapy as evidenced by remaining ambulatory (able to walk with or without assistance, not wheelchair dependent); and 2) An updated 6MWD is provided documenting patient is able to achieve a distance of at least 180 meters.

☐ **Exondys 51** **Dosage instructions**:____________________________ **Quantity**:______ **Days supply**:________

Diagnosis (attach results of genetic testing):____

Patient's weight (kg):_______________ **Date obtained**:________________________________

Please indicate setting in which Exondys is to be administered:____

Initial Requests

Does Prescriber specialize in treatment of DMD? ☐ Yes ☐ No If no, note consultation with Specialist:

Consultation date:___________________ Physician name & phone:____

Is patient ambulatory (able to walk with or without assistance, not wheelchair bound)? ☐ Yes ☐ No

Result of baseline 6MWD (in meters):_____________________________ **Date completed**:______________________

Is patient currently stable on an oral corticosteroid regimen for at least 6 months? ☐ No ☐ Yes (document below)

Oral corticosteroid trial: Drug name:__________________________________ Strength:______________________________

Dosing instructions:____ Trial start date:________________________

Renewal Requests

Does patient remain ambulatory (able to walk with or without assistance, not wheelchair bound)? ☐ Yes ☐ No

Result of subsequent 6MWD (in meters):__________________________ **Date completed**:______________________

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*