AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Exondys 51

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity per 30 days: _____
11. Length of Therapy: __up to 30 days ___60 days ___90 days __120 days __180 days

**Clinical Information**

**For initial authorization requests:**

1. What is the beneficiary's weight? _____
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy? Yes___ No___
3. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 51 skipping? Yes___ No___
4. Is Exondys 51 being prescribed by or in consultation with a neurologist? Yes___ No___
5. Is the beneficiary taking any other RNA antisense agent or any other gene therapy? Yes___ No___
6. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week? Yes___ No___

**For reauthorization:**

7. Please attach documentation that shows the beneficiary:
   __ Has shown an improvement in dystrophin levels **OR**
   __ Is not ventilator dependent **OR**
   __ Has some functional use of upper extremities **OR**
   __ Has an ability to walk with or without assistive devices

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**