HUSKY Health Program
Gene-Based Exon-Skipping Therapy for DMD
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information			
Member ID Number:		Member Name (Last, First):	
DOB:	Sex:	Address:	City, State, Zip:
Diagnosis Code:		HCPCS Code:	Dose:
From Date of Service:		To Date of Service:	

Please fill out completely for ALL initial and reauthorization requests.		
1. Treatment being requested: ☐ **Amondys 45®** (casimersen) ☐ **Exondys 51** (eteplirsen) ☐ **Viltepso®** (viltolarsen) ☐ **Vyondys 53®** (golodirsen)		
2. Type of request: ☐ Initial ☐ Reauthorization		
3. Does the ordering physician specialize in the treatment of Duchenne muscular dystrophy (DMD), or have they consulted with a physician who specializes in the treatment of DMD? ***If yes, please specify:*** Provider Name: _____ Phone Number: _____	○ Yes	○ No
4. Has the individual previously received gene replacement therapy for DMD (e.g., Elevidys)? a. If yes, has the individual experienced a worsening in clinical status? ***Please attach signed provider attestation.***	○ Yes ○ Yes	○ No ○ No
5. Will the individual be on concomitant therapy with another DMD gene-based, exon-skipping therapy? ***Please attach signed provider attestation.***	○ Yes	○ No
Please fill out completely for Amondys 45 (casimersen) requests ONLY:		
1. Does the individual have a diagnosis of DMD with a mutation amenable to exon 45 skipping, confirmed by genetic testing? ***Please attach results of genetic testing.***	○ Yes	○ No
2. For *initial* requests only: ***Please attach medical record documentation and test results.*** a. Is the individual ambulatory? b. Have baseline age-appropriate motor function tests been performed? c. Is the individual able to walk a distance of at least 300 meters independently over six minutes? d. Have baseline pulmonary function tests been performed, confirming that the forced vital capacity (FVC) ≥50% predicted?	 ○ Yes ○ Yes ○ Yes ○ Yes	 ○ No ○ No ○ No ○ No
3. Will the treating provider follow all FDA-approved labeling for dosing, administration, and monitoring of Amondys 45®?	○ Yes	○ No
4. For *reauthorization* requests only: Does treatment with Amondys 45® continue to show a beneficial clinical response? ***Please attach signed letter and clinical documentation from the ordering physician outlining benefits of treatment.***	○ Yes	○ No
Please fill out completely for Exondys 51 (eteplirsen) requests ONLY:		
1. Does the individual have a diagnosis of DMD with mutation amenable to exon 51 skipping, confirmed by genetic testing? ***Please attach results of genetic testing.***	○ Yes	○ No
2. For initial requests only: ***Please attach medical record documentation and test results.*** a. Have baseline age-appropriate motor function tests been performed? b. Does the individual retain meaningful voluntary motor function? c. Have baseline pulmonary function tests been performed, confirming that the forced vital capacity (FVC) ≥50% predicted?	 ○ Yes ○ Yes ○ Yes	 ○ No ○ No ○ No
3. Will the treating provider follow all FDA-approved labeling for dosing, administration, and monitoring of Exondys 51?	○ Yes	○ No
4. For *reauthorization* requests only: Does treatment with Exondys 51 continue to show a beneficial clinical response? ***Please attach signed letter and clinical documentation from the ordering physician outlining benefits of treatment.***	○ Yes	○ No

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Please fill out completely for Viltepso® (viltolarsen) requests ONLY:		
1. Does the individual have a diagnosis of DMD with mutation amenable to exon 53 skipping, confirmed by genetic testing? ***Please attach results of genetic testing.***	◯Yes	◯No
2. For initial requests only: ***Please attach medical record documentation and test results.***		
a. Is the individual ambulatory?	◯Yes	◯No
b. Has at least ONE of the following baseline age-appropriate motor function tests been performed? ***Please select "yes" for all that apply and attach results.***	◯Yes	◯No
i. Time to Stand Test (TTSTAND)	◯Yes	◯No
ii. Time to Run/Walk 10 Meters Test (TTRW)	◯Yes	◯No
iii. Six-minute Walk Test (6MWT)	◯Yes	◯No
iv. North Star Ambulatory Assessment (NSAA)	◯Yes	◯No
v. Time to Climb 4 Steps Test (TTCLIMB)	◯Yes	◯No
vi. Hand-held dynamometer (elbow extension, elbow flexion, knee extension, and knee flexion on the dominant side only)	◯Yes	◯No
c. Have baseline pulmonary function tests been performed, confirming that the forced vital capacity (FVC) ≥50% predicted?	◯Yes	◯No
3. Will the treating provider follow all FDA-approved labeling for dosing, administration, and monitoring of Viltepso®?	◯Yes	◯No
4. For *reauthorization* requests only: Does treatment with Viltepso® continue to show a beneficial clinical response? ***Please attach signed letter and clinical documentation from the ordering physician outlining benefits of treatment.***	◯Yes	◯No
Please fill out completely for Vyondys 53® (golodirsen) requests ONLY:		
1. Does the individual have a diagnosis of DMD with mutation amenable to exon 53 skipping, confirmed by genetic testing? ***Please attach results of genetic testing.***	◯Yes	◯No
2. For *initial* requests only: ***Please attach medical record documentation and test results.***		
a. Is the individual ambulatory?	◯Yes	◯No
b. Have baseline age-appropriate motor function tests been performed?	◯Yes	◯No
c. Is the individual able to walk an average distance of 250 meters independently over six minutes?	◯Yes	◯No
d. Have baseline pulmonary function tests been performed, confirming that the forced vital capacity (FVC) ≥50% predicted?	◯Yes	◯No
3. Will the treating provider follow all FDA-approved labeling for dosing, administration, and monitoring of Vyondys 53®?	◯Yes	◯No
4. For *reauthorization* requests only: Does treatment with Vyondys 53® continue to show a beneficial clinical response? ***Please attach signed letter and clinical documentation from the ordering physician outlining benefits of treatment.***	◯Yes	◯No

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

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Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.	
Provider Signature:	Date: