HUSKY Health Program
Gene-based 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 #:		Member Name (Last, First):	
DOB:	Sex:	Diagnosis Code:	HCPCS Code:
Address:		City, State, Zip:	

Please fill out completely for both initial and reauthorization requests.		
1. Treatment being requested: Eteplirsen Golodirsen Viltolarsen Casimersen		
2. 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?	□ Yes	□ No
3. Does the patient have a diagnosis of DMD with mutation amenable to exon 51 skipping?	□ Yes	□ No
4. Does the patient have a diagnosis of DMD with mutation amenable to exon 53 skipping?	□ Yes	□ No
5. Does the patient have a diagnosis of DMD with mutation amenable to exon 45 skipping?	□ Yes	□ No
6. Is the patient currently receiving treatment with corticosteroids unless contraindicated or not tolerated?	□ Yes	□ No
7. Have baseline age-appropriate motor and pulmonary function tests been performed? ***Please attach results (initial requests only)***	□ Yes	□ No
8. Will the physician follow all FDA recommendations for dosing, administration, and monitoring?	□ Yes	□ No
9. Is the patient on concomitant therapy with another DMD-directed antisense oligonucleotide?	□ Yes	□ No
Please answer the following question for reauthorization requests only.		
Is the patient benefiting from therapy? ***Please attach signed letter from 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:	

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: