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:	Address:	City, State Zip:
Diagnosis Code:		HCPCS Code:	Start Date of Service:

Please fill out completely for all initial and reauthorization requests.		
1. Treatment being requested: a. **Exon-Skipping Gene Therapy**: ☐ Eteplirsen ☐ Golodirsen ☐ Viltolarsen ☐ Casimersen b. **Micro-Dystrophin Gene Therapy:** ☐ Delandistrogene moxeparvovec-rokl		
2. Type of request: ☐ Initial ☐ Reauthorization *Note: reauthorization requests for delandistrogene moxeparvovec-rokl are not considered medically necessary.*		
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?	◯ Yes	◯ No
4. Will the physician follow all FDA recommendations for dosing, administration, and monitoring?	◯ Yes	◯ No
Please fill out completely for Exon-Skipping Gene Therapy requests ONLY:		
1. Does the patient have a diagnosis of DMD with mutation amenable to exon 51 skipping, confirmed by genetic testing? ***If yes, please attach results of genetic testing.***	◯ Yes	◯ No
2. Does the patient have a diagnosis of DMD with mutation amenable to exon 53 skipping, confirmed by genetic testing? ***If yes, please attach results of genetic testing.***	◯ Yes	◯ No
3. Does the patient have a diagnosis of DMD with mutation amenable to exon 45 skipping, confirmed by genetic testing? ***If yes, please attach results of genetic testing.***	◯ Yes	◯ No
4. Is the patient on concomitant therapy with another DMD gene-based exon-skipping therapy?	◯ Yes	◯ No
5. For *initial* requests only: Have baseline age-appropriate motor and pulmonary function tests been performed? ***If yes, please attach results.***	◯ Yes	◯ No
6. For *reauthorization* requests only: Does treatment with exon-skipping therapy continue to be medically necessary? ***Please attach signed letter from ordering physician outlining benefits of treatment.***	◯ Yes	◯ No
Please fill out completely for Micro-Dystrophin Gene Therapy requests ONLY:		
1. Does the patient have a diagnosis of DMD with a mutation in the DMD gene, confirmed by genetic testing? ***If yes, please attach results of genetic testing.***	◯ Yes	◯ No
2. Does the patient have a deletion in exon 8 and/or exon 9 in the DMD gene? ***Please attach results of genetic testing.***	◯ Yes	◯ No
3. Is the patient four years of age or older?	◯ Yes	◯ No
4. Does the patient have an elevated anti-AAVrh74 total binding antibody titer ≥ 1:400? ***Please attach results of antibody titer.***	◯ Yes	◯ No
5. Has the patient previously received delandistrogene moxeparvovec-rokl?	◯ Yes	◯ No

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

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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: