HUSKY Health Program EXONDYS™ (eteplirsen)
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:	Wt:	Primary Diagnosis Code:
Address:			City, State, Zip:

Please fill out completely for both initial and reauthorization requests.		
1. Does the ordering physician specialize in the treatment of Duchenne muscular dystrophy (DMD)?	○ Yes	○ No
2. Has the ordering physician 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 confirmed by genetic testing? ***Please attach genetic testing results.***	○ Yes	○ No
4. Is the patient currently stable on an oral corticosteroid regimen for at least six months?	○ Yes	○ No
5. Is the patient currently ambulatory (able to walk with or without assistance, not wheelchair dependent?)	○ Yes	○ No
6. Is the patient currently able to achieve an average distance of at least 180 meters while walking independently for over six minutes? ***Please attach 6-Minute Walk Test results.***	○ Yes	○ No
7. Will the dosing regimen follow the FDA recommendations of 30 mg/kg once per week?	○ Yes	○ No
8. If response to # 7 is "No", what dosage will be given:		

Please fill out completely for reauthorization requests.		
1. Has the patient demonstrated a response to therapy as evidenced by remaining ambulatory (able to walk with or without assistance, not wheelchair dependent)	○ Yes	○ No
2. Has an updated 6MWT been performed that indicates that the patient is able to achieve a distance of at least 180 meters? ***Please attach 6-Minute Walk Test results.***	○ Yes	○ No

For additional information refer to the EXONDYS 51™ (eteplirsen) clinical policy located on www.ct.gov/husky by clicking "**For Providers**" followed by "**Policies, Procedures, and Guidelines**" under the Medical Management sub-menu. Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

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: