AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Amondys 45

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 45 skipping? Yes___ No___
4. Is Amondys 45 being prescribed by or in consultation with a neurologist? Yes___ No___
5. Does the beneficiary retain meaningful voluntary motor function (beneficiary is able to speak, manipulate objects using upper extremities, ambulate, etc.)? Yes___ No___
6. Has the beneficiary been assessed for any physical therapy and/or occupational therapy needs? Yes___ No___
7. Has the beneficiary's serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio (UPCR) been measured prior to starting therapy? Yes___ No___
8. Does the prescriber attest that serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio will be measured during treatment (monthly urine dipstick with serum cystatin C and urine protein-to-creatinine ratio every 3 months)? Yes___ No___
9. Has baseline documentation of at least 1 of the following been performed: Dystrophin level, 6-minute walk test (6MWT) or other timed function tests, Upper limb function (ULM) test, North Star Ambulatory Assessment (NSAA), Forced Vital Capacity (FVC) % predicted, of Performance or Upper Limb (PUL)? Yes___ No___ List:_____
10. Is the beneficiary taking any other RNA antisense agent or any other gene therapy? Yes___ No___
11. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week? Yes___ No___

For reauthorization: (answer 1-11)

12. Please attach documentation that shows the beneficiary has demonstrated a response to therapy compared to pretreatment baseline in at least 1 of the following:

__ Increase in dystrophin level; **OR**
__ Stability, improvement, or slowed rate of decline in 6MWT or other timed function tests; **OR**
__ Stability, improvement, or slowed rate of decline in ULM test; **OR**
__ Stability, improvement, or slowed rate of decline in NSAA; **OR**
__ Stability, improvement, or slowed rate of decline in FVC% predicted; **OR**
__ Improvement in quality of life; **and** that the beneficiary has not experienced any treatment-restricting adverse effects (e.g., renal toxicities, proteinuria)

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