CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
MUSCULAR DYSTROPHY AGENTS PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider. All sections must be completed or the request will be returned.

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact:
Prescriber's Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber Address:	Date(s) of Service: _____ Start Date: _____

Requested Medication	Quantity	Requested Dose and Frequency

Request is for: ☐ **Initiation of therapy** ☐ **Continuation of therapy** **Diagnosis Code:** _____

PA Requirements for Amondys 45 (casimersen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 45 skipping (please include documentation).

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g. Brooke Score, 6 minute walk test, etc.).

Member weight: _____ ***(Note: Dose will be approved for 30mg/kg weekly)***

PA Requirements for EMFLAZA (deflazacort):

☐ Member is >/= 2 years of age

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation).

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g. Brooke Score, 6 minute walk test, pulmonary function tests, etc.

Member weight: _____

(***Note: Dose will be approved for 0.9mg/kg/day rounded to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension)***

PA Requirements for EXONDYS 51 (etepliresen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping (please include documentation),

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g. Brooke Score, 6 minute walk test, etc.).

Member weight: _____ ***(Note: Dose will be approved for 30mg/kg weekly)***

PA Requirements for VILTEPSO (viltolarsen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 53 skipping (please include documentation).

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g. Brooke Score, 6 minute walk test, etc.).

Member weight: _____ ***(Note: Dose will be approved for 80mg/kg weekly)***

PA Requirements for VYONDYS 53 (golodirsen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 53 skipping (please include documentation)

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g. Brooke Score, 6 minute walk test, etc.).

Member weight: _____ ***(Note: Dose will be approved for 30mg/kg weekly)***

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____