



**New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form**

Duchenne Muscular Dystrophy Agents

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Does the patient have a confirmed diagnosis of Duchenne muscular dystrophy (DMD)? Yes No
- Exondys 51 only:** Has genetic testing been completed to identify a mutation on the DMD gene amenable to exon 51 skipping? Yes No
- Viltepro or Vyondys 53 only:** Has genetic testing been completed to identify a mutation on the DMD gene amenable to exon 53 skipping? Yes No
- Amondys 45 only:** Has genetic testing been completed to identify a mutation on the DMD gene amenable to exon 45 skipping? Yes No

(Form continued on next page.)

Fax to Prime Therapeutics Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.

Phone: 1-866-675-7755

Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

Phone: 1-603-271-9384

Fax: 1-603-314-8101





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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (CONTINUED)

5. Is the patient on a stable dose of corticosteroids? Yes No

If **yes** to question 5, list the medication and start date:

If **no** to question 5, list the intolerance or contraindication:

6. Does the patient continue to have voluntary motor function? Yes No

7. Is the patient receiving physical and/or occupational therapy? Yes No

Amondys 45, Vyondys 53, and Viltepso® only:

8. Prior to initiating therapy, will serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio be measured? Yes No

9. Will the urine dipstick and serum cystatin C be measured monthly and urine protein-to-creatinine ratio by assessed every 3 months during therapy? Yes No

Viltepso® only:

10. Does the patient have symptomatic cardiomyopathy? Yes No

11. Has a baseline assessment been completed with at least one of the following? Yes No

- Dystrophin level
- 6-minute walk test (6MWT) or other timed test
- Upper limb module (ULM) score
- North Star Ambulatory Assessment (NSAA)
- Forced vital capacity (FVC)% predicted

(Form continued on the next page.)

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SECTION III: CLINICAL HISTORY (CONTINUED)

11. **For renewals (every 120 days):** Patient must demonstrate stability, improvement, or slowed rate of progression in one of the above assessments.

Renewal assessment results:

Please provide any additional information that would help in the decision-making process. **If additional space is needed, please use a separate sheet.**

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.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____

Facility where infusion is to be provided: _____

Medicaid provider number of facility: _____

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