OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Exondys 51® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Duchenne muscular dystrophy (DMD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is there documentation the patient has a confirmed mutation of the dystrophin gene amenable to exon 51 skipping? ❑ **Yes** ❑ **No**

Is the patient ambulatory? ❑ **Yes** ❑ **No**

Is Exondys 51 prescribed by or in consultation with a neurologist who has experience treating children? ❑ **Yes** ❑ **No**

Has the patient's condition been evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [documentation of the patient's most recent results must be provided]? ❑ **Yes** ❑ **No**

Is the Exondys 51 dosing for DMD in accordance with the United States Food and Drug Administration approved labeling (maximum dosing of 30 mg/kg infused once weekly)? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient been on therapy for less than 12 months? ❑ **Yes** ❑ **No**

Is the patient maintaining ambulatory status? ❑ **Yes** ❑ **No**

Is the patient tolerating therapy? ❑ **Yes** ❑ **No**

Is the Exondys 51 dosing for DMD in accordance with the United States Food and Drug Administration approved labeling (maximum dosing of 30 mg/kg infused once weekly)? ❑ **Yes** ❑ **No**

Is Exondys 51 prescribed by or in consultation with a neurologist who has experience treating children? ❑ **Yes** ❑ **No**

If the patient has been on therapy for MORE THAN 12 months, also answer the following question:

Has the patient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.