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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)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Duchenne muscular dystrophy (DMD)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p>Clinical Information:</p> <p>Is there documentation the patient has a confirmed mutation of the dystrophin gene amenable to exon 51 skipping? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Exondys 51 prescribed by or in consultation with a neurologist who has experience treating children? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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]? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Reauthorization:</p> <p>Has the patient been on therapy for less than 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient maintaining ambulatory status? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient tolerating therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Exondys 51 prescribed by or in consultation with a neurologist who has experience treating children? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the patient has been on therapy for MORE THAN 12 months, also answer the following question:</p> <p>Has the patient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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.

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 Office use only: Exondys51_CMS_2019Jan-W