Vyondys 53

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: _______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Vyondys 53 SGM – 11/2021.

Criteria Questions:

1. What is the diagnosis?
   ❑ Duchenne muscular dystrophy
   ❑ Other ____________________________________
2. What is the ICD-10 code? ______________
3. What is the patient's weight in kilograms? ____________ kg
4. Is the requested drug prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy? ❑ Yes ❑ No
5. Will the requested medication be used concomitantly with vitolarsen (Viltepso)? ❑ Yes ❑ No
6. Does the patient's dose exceed 30 mg/kg once weekly? ❑ Yes ❑ No
7. Is the request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #10*
8. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to # 10* ❑ Yes ❑ No ❑ Unknown
9. Has the patient demonstrated a response to therapy as evidenced by remaining ambulatory (e.g., able to walk with or without assistance, not wheelchair dependent)? ***ACTION REQUIRED: If Yes, attach documentation (e.g., chart notes) of response to therapy.*** ❑ Yes ❑ No *No further questions*
10. Was genetic testing conducted to confirm the diagnosis of Duchenne muscular dystrophy? ❑ Yes ❑ No
11. Was genetic testing conducted to identify the specific type of DMD gene mutation? ***ACTION REQUIRED: If Yes, attach a copy of the genetic testing results.***
    ❑ Yes - Please indicate the DMD gene mutation _____________ ❑ No
12. Is the DMD gene mutation amenable to exon 53 skipping? ❑ Yes ❑ No
13. Is the patient able to achieve an average distance of at least 250 meters while walking independently over 6 minutes? ❑ Yes ❑ No
14. Will treatment with the requested drug be initiated prior to age 16? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Vyondys 53 SGM – 11/2021.