

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

Duchenne Muscular Dystrophy Agents

DATE OF MEDICATION REQUEST: / /

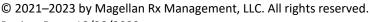
SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED													
LAST NAME:	FIRST NAME:												
MEDICAID ID NUMBER:	DATE OF BIRTH:												
GENDER: Male Female													
Drug Name:	Strength:												
Dosing Directions:	Length of Therapy:												
SECTION II: PRESCRIBER INFORMATION													
LAST NAME:	FIRST NAME:												
SPECIALTY:	NPI NUMBER:												
PHONE NUMBER:	FAX NUMBER:												
SECTION III: CLINICAL HISTORY													
. Does the patient have a confirmed diagnosis of Duchenne Muscular Dystrophy?													
Exondys 51 only: Has genetic testing been completed to identify a mutation on the DMD gene													
8. Viltepso or Vyondys 53 only: Has genetic testing been completed to identify a mutation on the DMD gene amenable to exon 53 skipping?													
Amondys 45 only: Has genetic testing been completed to identify a mutation on the DMD gene Yes No amenable to exon 45 skipping?													
(Form continued on next page)													

Fax to Magellan Rx 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



Review Date: 10/28/2022





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PATIENT LAST NAME:						ı	PATIENT FIRST NAME:																	
SE	CTIC	II NC	I: CLIN	IICAL	HIST	ORY	(COI	VTIN	UED))														
5. Is the patient on a stable dose of corticosteroids?										Ye	es [No												
	a.	If ye	s to q	uestic	on 5,	list tl	he m	edic	ation	and	start	dat	te:											
b. If no to question 5, list the intolerance or contraindication:																								
6. Does the patient continue to have voluntary motor function?									Ye	es [No													
7. Is the patient receiving physical and/or occupational therapy?								Ye	es [No														
8.	Am	ond	ys 45,	Vyon	dys 5	3, ar	nd Vi	ltep	so® c	nly:														
a. Prior to initiating therapy, will serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio be measured?								Ye	es [No														
b. Will the urine dipstick and serum cystatin C be measured monthly and urine protein-to-creatinine ratio by assessed every 3 months during therapy?									Ye	es [No													
9. Viltepso® only: Does the patient have symptomatic cardiomyopathy?								Ye	es [No														
10	. Has		aseline				een o	comp	olete	d wit	h at l	eas	t one	of t	he fo	ollow	/ing?					Ye	es [] No
			Dystro 5-mini	-			MW	T) or	othe	er tin	ned te	est												
			Jpper			•		-																
		•	North	Star A	٩mbu	ılatoı	y As	sess	ment	(NS	AA)													
		•	orce	l Vita	l Cap	acity	(FVC	:)% p	redio	ted														

(Form continued on the next page.)

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SECTION III: CLINICAL HISTORY (CONTINUED)													
11. For renewals (every 120 days): Patient must demonstrate in one of the above assessments. Renewal assessment results:	te stability, improvement, or slowed rate of progression												
Please provide any additional information that would help in needed, please use a separate sheet.	n the decision-making process. If additional space is												
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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