



**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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GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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**SECTION III: CLINICAL HISTORY**

- Does the patient have a confirmed diagnosis of Duchenne Muscular Dystrophy?     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
- Viltepto 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 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



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PATIENT LAST NAME:

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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

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

b. 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

8. **Amondys 45, Vyondys 53, and Viltepso® only:**

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

9. **Viltepso® only:** Does the patient have symptomatic cardiomyopathy?  Yes  No

10. 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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