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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

1. Does the patient have a confirmed diagnosis of Duchenne Muscular Dystrophy? ☐ Yes ☐ No
2. **Exondys 51 only:** Has genetic testing been completed to identify a mutation on the DMD gene amenable to exon 51 skipping? ☐ Yes ☐ No
3. **Viltepso or Vyondys 53 only:** Has genetic testing been completed to identify a mutation on the DMD gene amenable to exon 53 skipping? ☐ Yes ☐ No
4. **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

Review Date: 10/28/2022

Magellan Rx MANAGEMENT℠

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PATIENT LAST NAME:

PATIENT FIRST NAME:

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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