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CardinalCare
Virginia's Medicaid Program

Service Authorization (SA) Form

ANTISENSE OLIGONUCLEOTIDES FOR DUCHENNE MUSCULAR DYSTROPHY

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Expected Pregnancy Term Date: _____

Requested Start Date: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to page 3 of this form.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

If the physician does not have the necessary information, the request will be denied and the fax form requesting additional information will be sent to the prescriber.

Initial coverage for all medications will be limited to the following:

1. Does the member have a confirmed diagnosis of Duchenne muscular dystrophy (DMD) with **one** of the following? **AND**
   - ☐ For Amondys 45™: A confirmed mutation of the DMD gene that is amendable to exon 45 skipping; **OR**
   - ☐ For Exondys 51™: A confirmed mutation of the DMD gene that is amendable to exon 51 skipping; **OR**
   - ☐ For Vyondys 53™ or Viltepso®: A confirmed mutation of the DMD gene that is amendable to exon 53 skipping
2. Has the member been on a stable dose of corticosteroids unless there is a contraindication or intolerance? **AND**

   ☐ Yes ☐ No
3. Will the requested agent be used as the only exon skipping therapy for the member's DMD?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Renewal coverage for all medications will be limited to the following:

4. Does the member continue to meet the initial criteria? **AND**

   ☐ Yes ☐ No

5. Does the member have an absence of unacceptable toxicity to the drug? **AND**

   ☐ Yes ☐ No

6. Is the member being appropriately monitored for a beneficial response to therapy?

   ☐ Yes ☐ No

☐ Attachments

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information. Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED to 800-932-6651**, phoned to 800-932-6648, or mailed to:

Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811