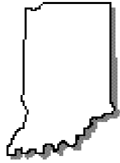
MUSCULAR DYSTROPHY AGENTS PRIOR AUTHORIZATION REQUEST FORM



OptumRx
P.O. Box 25184
Santa Ana, CA, 92799
Phone: (800) 310-6826 Fax: (866) 577-6384

Today's Date
__ __ / __ __ / __ __ __ __

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid #	Date of Birth / /
Patient's Name	Prescriber's Name
Prescriber's IN License #	Specialty
Prescriber's NPI #	Prescriber's Signature
Return Fax # - -	Return Phone # - -
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Requested Dose and Frequency

Request is for: ☐ **Initiation of therapy** ☐ **Continuation of therapy**

PA Requirements for AGAMREE (vamorolone)

☐ Member is >/= 2 years of age

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation)

Member has had previous trial and failure history of at least 90 days of therapy with Emflaza (deflazacort, Jaythari, Kymbee, Pyquvi)

☐ Yes ☐ No

- Dates of trial:
  - Start date:______________________________
  - Stop date: ______________________________

If not, please provide medical justification for use of Agamree (vamorolone) over Emflaza (deflazacort, Jaythari, Kymbee, Pyquvi)

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☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g., Brooke Score, 6-minute walk test, pulmonary function tests, etc)

Member weight: ______________________________________

(Note: Dose will be approved for 6mg/kg/day (max: 300 mg/day or 2 bottles every 25 days), rounded to the nearest tenth of a milliliter of oral suspension)

PA Requirements for Amondys 45 (casimersen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 45 skipping (please include documentation)

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g., Brooke Score, 6-minute walk test, etc.)

Member weight: ______________________________________

(Note: Dose will be approved for 30mg/kg weekly)

PA Requirements for DUVYZAT (givinostat)

☐ Member is >/= 6 years of age

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation)

☐ Member has previous trial and failure history of at least 90 days of therapy with Agamree (vamorolone) OR Emflaza (deflazacort, Jaythari, Kymbee, Pyquvi) as single agent therapy ☐ Yes ☐ No

- Medication name:___________________________
- Dates of trial:
  - Start date:___________________________
  - Stop date (N/A if continuing):___________________________

If not, please provide medical justification for use of Duvyzat (givinostat) over both Agamree (vamorolone) AND Emflaza (deflazacort, Jaythari, Kymbee, Pyquvi)

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☐ Member is ambulatory prior to initiation of therapy (please include documentation)

Prescriber attests to all of the following:

- Prescriber has obtained baseline platelet count and triglycerides prior to initiating therapy ☐ Yes ☐ No
- Baseline platelet count is 150 x 10^9 L or greater ☐ Yes ☐ No
- Prescriber will continue to monitor platelet count and triglycerides and adjust dosing per the prescribing information ☐ Yes ☐ No

I, ____hereby attest that member qualifies for initiation of therapy based on the criteria above.

Prescriber Signature: ____

(Note: Dose will be approved for up to 53.2 mg twice daily (3 bottles/35 days)

For reauthorization only:

☐ Member continues to be ambulatory (please include documentation)

☐ Prescriber has submitted documentation (e.g., current and previous chart notes) explicitly supporting improvement (including disease stabilization) in current clinical status (e.g., 4-stair climb time, North Star Ambulatory Assessment (NSAA), 6-minute walk test, etc.)

PA Requirements for EMFLAZA (deflazacort, Jaythari, Kymbee, Pyquvi)*:

☐ Member is >/= 2 years of age

☐ Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing (please include documentation)

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g., Brooke Score, 6-minute walk test, pulmonary function tests, etc.

Member weight: ______________________________________

(Note: Dose will be approved for 0.9mg/kg/day rounded to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension)

**(Note: plan prefers brand name Emflaza; requests for deflazacort, Jaythari, Kymbee, or Pyquvi will require generic medically necessary PA review)*

PA Requirements for EXONDYS 51 (eteplirsen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping (please include documentation)

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g., Brooke Score, 6-minute walk test, etc.)

Member weight: ______________________________________

(Note: Dose will be approved for 30mg/kg weekly)

PA Requirements for VILTEPSO (viltolarsen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 53 skipping (please include documentation)

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g., Brooke Score, 6-minute walk test, etc.)

Member weight: ______________________________________

(Note: Dose will be approved for 80mg/kg weekly)

PA Requirements for VYONDYS 53 (golodirsen):

☐ Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 53 skipping (please include documentation)

☐ Prescriber has conducted testing to determine current clinical status and submitted with prior authorization request (e.g., Brooke Score, 6-minute walk test, etc.)

Member weight: ______________________________________

(Note: Dose will be approved for 30mg/kg weekly)

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