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 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 a mutation on the DMD gene amenable to exon 53 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: 1-603-271-8194

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Effective Date: 04/15/2021

Magellan Rx MANAGEMENT℠

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

4. Is the patient on a stable dose of corticosteroids? ☐ Yes ☐ No
   a. If *yes* to question 4, what medication and start date:

   b. If *no* to question 4, what is the intolerance or contraindication

5. Does the patient continue to have voluntary motor function? ☐ Yes ☐ No
6. Is the patient receiving physical and/or occupational therapy? ☐ Yes ☐ No
8. ***Viltepso® only:***
   a. Does the patient have symptomatic cardiomyopathy? ☐ Yes ☐ No
   b. Prior to initiating therapy, will serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio be measured? ☐ Yes ☐ No
   c. 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. 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

   For renewals (every 120 days), patient must demonstrate stability, improvement, or slowed rate of progression in one of the above assessments.

   Renewal assessment results:

(Form continued on the next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

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 to be provided: _____

Medicaid Provider Number of Facility: _____

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