AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa Request for Prior Authorization

Eteplirsen (Exondys 51)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for Exondys 51 (eteplirsen). Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with mutation amenable to exon 51 skipping confirmed by genetic testing (attach results of genetic testing); and 2) Is prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy; and 3) Patient is currently ambulatory; and 4) A baseline 6-Minute Walk Distance (6MWD) is provided and patient is able to achieve a distance of at least 180 meters while walking independently; and 5) Patient is currently stable on an oral corticosteroid regimen for at least 6 months; and 6) Is dosed based on FDA approved dosing: 30 mg/kg once weekly; and 7) Medication is to be administered by a healthcare professional in member's home by home health or in a long-term care facility. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. When criteria for coverage are met, an initial authorization will be given for 6 months. Requests for continuation of therapy will be considered at 6 month intervals when the following criteria are met: 1) Patient has demonstrated a response to therapy as evidenced by remaining ambulatory (able to walk with or without assistance, not wheelchair dependent); and 2) An updated 6MWD is provided documenting patient is able to achieve a distance of at least 180 meters.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

☐ **Exondys 51**

Dosage Instructions: Quantity: Days Supply:

Diagnosis (attach results of genetic testing):

Patient's weight (kg): Date obtained:

Please indicate setting in which Exondys is to be administered:

Initial Requests

Does Prescriber specialize in treatment of DMD? Yes No If no, note consultation with Specialist:

Consultation date: Physician name & phone:

Is patient ambulatory (able to walk with or without assistance, not wheelchair bound)? Yes No

Result of baseline 6MWD (in meters): Date completed:

Is patient currently stable on an oral corticosteroid regimen for at least 6 months? No Yes (document below)

Oral corticosteroid trial: Drug name: Strength:

Dosing instructions: Trial start date:

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Renewal Requests

Does patient remain ambulatory (able to walk with or without assistance, not wheelchair bound)? Yes No

Result of subsequent 6MWD (in meters): Date completed:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.