# UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

## Exondys 51 (eteplirsen)

### Member and Medication Information (required)

<table>
<thead>
<tr>
<th>Member ID:</th>
<th>Member Name:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>Weight:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medication Name/ Strength:</th>
<th>Dose:</th>
</tr>
</thead>
</table>

Directions for use:

### Provider Information (required)

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPI:</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact Person:</th>
<th>Office Phone:</th>
<th>Office Fax:</th>
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</thead>
</table>

All information to be legible, complete and correct or form will be returned. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

### Criteria for Approval:
- Laboratory Confirmation of DMD gene mutation amenable to exon 51 skipping diagnosis by genetic testing; **AND**
- Prescribed by, or in consultation with a neurologist experienced in the treatment of Duchenne muscular dystrophy; **AND**
- Dosing is in accordance with FDA approved labeling

### Re-authorization Criteria:
- Updated letter of medical necessity or updated chart notes demonstrating positive clinical response to therapy; **AND**
- Prescribed by, or in consultation with a neurologist experienced in the treatment of Duchenne muscular dystrophy;

### Note:
Use appropriate HCPCS code for billing

### Initial Authorization: One year

### Re-authorization: One year

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**PROVIDER CERTIFICATION**

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

__________________________________________    ____________________  
Prescriber’s Signature                   Date