Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Duchenne Muscular Dystrophy: Exondys 51

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Exondys 51** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For initial authorization requests:

1. What is the member's weight? _____
2. Does the member have a diagnosis of Duchenne Muscular Dystrophy? ☐ **Yes** ☐ **No**
3. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 51 skipping? ☐ **Yes** ☐ **No**
4. Is Exondys 51 being prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**
5. Is the member taking any other RNA antisense agent or any other gene therapy? ☐ **Yes** ☐ **No**
6. Is the member receiving a dose that does not exceed 30mg/kg once per week? ☐ **Yes** ☐ **No**

For reauthorization:

7. Please attach documentation that shows the member:
   - ☐ Has shown an improvement in dystrophin levels **OR**
   - ☐ Is not ventilator dependent **OR**
   - ☐ Has some functional use of upper extremities **OR**
   - ☐ Has an ability to walk with or without assistive devices

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

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.