



# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Exondys 51™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

### Member Information (required) Provider Information (required)

Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

### Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

### Clinical Information (required)

**Select the diagnosis below:**

Duchenne Muscular Dystrophy (DMD)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical Information:**

Is there documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping?  Yes  No

Is the medication prescribed by or in consultation with a neurologist who has experience treating children?  Yes  No

Does the prescribed dose exceed 30 mg/kg of body weight once weekly?  Yes  No

**Reauthorization:**

**If this is a reauthorization request, answer the following questions:**

Has the recipient experienced a clinically significant benefit?  Yes  No

Is the recipient tolerating therapy?  Yes  No

Is the medication prescribed by or in consultation with a neurologist who has experience treating children?  Yes  No

Does the prescribed dose exceed 30 mg/kg of body weight once weekly?  Yes  No

Has the recipient been on therapy for 12 months or more?  Yes  No

If **Yes**, answer the following:

Has the recipient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)?  Yes  No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-855-455-3303.

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