



Nevada Medicaid

Submit fax request to: 855-455-3303

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

Vyondys 53® (golodirsen) 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 brand <input type="checkbox"/> Check if request is for initial trial <input type="checkbox"/> Check if request is for recertification of therapy			Directions for Use:		
Clinical Information (required)					
Prescriber to submit medical records (e.g., chart notes, laboratory values) documenting both the following:					
<input type="checkbox"/> Diagnosis of Duchenne Muscular Dystrophy. <input type="checkbox"/> Documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping.					
Drug-Specific Information (required)					
<input type="checkbox"/> The medication is prescribed by or in consultation with a neurologist who has experience treating children. <input type="checkbox"/> The dose will not exceed 30 milligrams per kilogram of body weight infused once weekly.					
For recertification (in addition to criteria above):					
<input type="checkbox"/> The recipient is tolerating therapy. <input type="checkbox"/> The recipient experienced a benefit from therapy.					

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

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 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**