



Nevada Medicaid

Submit fax request to: 855-455-3303

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

Amondys 45[®] (casimersen) 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 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 45 skipping					
Drug-Specific Information (required)					
Select all that apply:					
<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					

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.

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