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:
❑ Check if request is for initial trial ❑ 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:

- ❑ Diagnosis of Duchenne Muscular Dystrophy
- ❑ Documentation of a confirmed mutation of the dystrophin gene amenable to exon 45 skipping

Drug-Specific Information (required)

Select all that apply:

- ❑ The medication is prescribed by or in consultation with a Neurologist who has experience treating children
- ❑ The dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

For recertification (in addition to criteria above):

- ❑ 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.