{{PANUMCODE}}

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   ❑ Duchenne muscular dystrophy (DMD) ❑ Other _____
2. What is the ICD-10 code? _____
3. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three. The formulary alternatives for the requested drug is Prednisone. Can the patient's treatment be switched to a formulary alternative? ***If Yes, fax a new prescription to pharmacy and no further questions.***
   ❑ Yes - Prednisone
   ❑ No - Continue request for non-preferred product
4. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative.
   ❑ Yes ❑ No

   Formulary alternative: Prednisone

   If Yes, indicate the formulary alternative(s) the patient has tried and the reason(s) for treatment failure and skip to #6.

   Drug name: _____ Reason for treatment failure: _____
5. Does the patient have a documented contraindication to all or at least three of the formulary alternative(s): Prednisone? ❑ Yes ❑ No

   If Yes, specify the formulary alternative(s) the patient is unable to take and describe the contraindication(s):

   Drug name: _____ Contraindication: _____
6. Have chart notes or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three been attached? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives***. ❑ Yes ❑ No

7. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing showing a mutation in the DMD gene? ***ACTION REQUIRED: If Yes, attach a copy of the laboratory report confirming DMD gene mutation and skip to #9.*** ❑ Yes ❑ No

8. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by a muscle biopsy demonstrating absent dystrophin? ***ACTION REQUIRED: If Yes, attach a copy of the patient's medical record confirming a muscle biopsy demonstrating absent dystrophin.*** ❑ Yes ❑ No

9. Which of the following applies to the patient?
   ❑ Patient has tried treatment with prednisone or prednisolone
   ❑ Patient has tried treatment with prednisone, prednisolone, or deflazacort *skip to question 16*
   ❑ None of the above

10. Did the patient experience unmanageable and/or clinically significant weight gain/obesity while receiving treatment with prednisone or prednisolone? ***ACTION REQUIRED: If Yes, attach chart documentation of weight gain/obesity with prednisone or prednisolone treatment.*** ❑ Yes ❑ No *If No, skip to question 14*

11. What is/was the patient's age at the time of prednisone or prednisolone treatment?
    ❑ 2 years to 19 years of age ❑ 20 years of age or older *skip to question 13*

12. What was the body mass index percentile while receiving treatment with prednisone or prednisolone? *Indicate Percentage.* _____(BMI percentile)

13. What was the body mass index while receiving treatment with prednisone or prednisolone?
    _____(BMI)

14. Did the patient experience unmanageable and/or clinically significant psychiatric/behavioral issues (e.g., abnormal behavior, aggression, irritability) while receiving treatment with prednisone or prednisolone? ***ACTION REQUIRED: If Yes, attach chart documentation of persistent psychiatric/behavioral issues with previous prednisone or prednisolone treatment***. ❑ Yes ❑ No *If No, skip to question 16*

15. Did the psychiatric or behavioral issues persist beyond the first 6 weeks of treatment with prednisone or prednisolone? *If Yes, skip to question 20* ❑ Yes ❑ No

16. Did the patient experience clinically significant growth stunting while receiving treatment with prednisone, prednisolone, or deflazacort? ***ACTION REQUIRED: If Yes, attach chart documentation of growth stunting with prednisone, prednisolone, or deflazacort treatment (where applicable).*** ❑ Yes ❑ No

17. Did the patient have a decline in mean height percentile for age from baseline?
    If Yes, skip to question 20 ❑ Yes ❑ No

18. Did the patient experience a decrease in growth trajectory and/or growth velocity?
    If Yes, skip to question 20 ❑ Yes ❑ No

19. Did the patient have a reduction in serum biomarkers of bone formation (e.g., osteocalcin, procollagen 1 intact N-terminal propeptide [P1NP]) and/or bone turnover (e.g., type 1 collage cross-linked C-telopeptide [CTX1])?
    ❑ Yes ❑ No

20. Is this request for continuation of therapy with the requested medication?
    ❑ Yes ❑ No *If No, no further questions.*

21. Is the patient receiving a clinical benefit from the requested medication therapy (e.g., improvement or stabilization in muscle strength and/or motor function)? ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date