BlueCross BlueShield Federal Employee Program

VYONDYS 53
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Vyondys 53 (golodirsen)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑ Duchenne Muscular Dystrophy (DMD)
   - ❑ Other diagnosis ***(please specify)***: _____

2. Will the patient be advised to monitor for hypersensitivity reactions? ❑Yes ❑No

3. Will the patient be taking another ***exon skipping therapy for Duchenne Muscular Dystrophy? ❑Yes ❑No
   Exon skipping therapy includes: Exondys 51 (eteplirsen) and Viltepso (viltolarsen)

4. Has the patient been on Vyondys 53 continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Does the patient have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping? ❑Yes ❑No
   - b. Has a baseline muscle strength score from one of the following tests been obtained or will be obtained prior to start of therapy: 6 Minute Walk Test (6MWT), North Star ambulatory assessment (NSAA), or Motor Function Measure (MFM)? ❑Yes ❑No
   - c. Will the patient's glomerular filtration rate be measured prior to initiation of therapy and monitored for renal toxicity during treatment? ❑Yes ❑No
   - d. Has Vyondys 53 been prescribed by or in consultation with a neurologist specializing in DMD? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   - a. Has the patient had an improvement from baseline from one of the following: 6 Minute Walk Test (6MWT), North Star ambulatory assessment (NSAA), or Motor Function Measure (MFM)? ❑Yes ❑No
   - b. Will the patient be monitored for renal toxicity during treatment? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***