Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Duchenne Muscular Dystrophy (DMD) Products – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

1. What is the member's diagnosis?
   □ Duchenne Muscular Dystrophy
   □ Other: _____

2. What is the member's weight? ____ lbs or ___ kg

3. Has the member been stable on systemic corticosteroid therapy for at least 24 weeks?
   □ Yes
   □ No – Please provide the reason why:
   _____
   **If due to a contraindication or significant adverse effect, please provide documentation.*

4. Is the requested drug being prescribed by or in consultation with a pediatric/adult neurologist or a physician who is an expert in the treatment of DMD or other neuromuscular disorders? □ **Yes or** □ **No**

5. Does the prescriber understand that continued approval of this indication may be contingent upon verification of a clinical benefit in confirmatory trials? □ **Yes or** □ **No**

6. Please indicate the drug being requested and answer corresponding questions/provide documentation.

   □ **Casimersen (Amondys 45®)**
   a. Will the member's kidney function be evaluated before and during treatment? □ **Yes or** □ **No**
   b. Please submit medical records for the following:
   - Genetic testing confirming the member has a mutation of the DMD gene that is amenable to exon 45 skipping
   - Baseline renal function tests (i.e., glomerular filtration rate [GFR])

   □ **Eteplirsen (Exondys 51®)**
   a. Please submit medical records for the following:
   - Genetic testing confirming the member has a mutation of the DMD gene that is amenable to exon 51 skipping

   □ **Golodirsen (Vyondys 53®) or Viltolarsen (Viltepso®)**
   a. Will the member use golodirsen (Vyondys 53®) together with viltolarsen (Viltepso®)?
   □ **Yes or** □ **No**
   b. Will the member's kidney function be evaluated before and during treatment? □ **Yes or** □ **No**
   c. Please submit medical records for the following:
   - Genetic testing confirming the member has a mutation of the DMD gene that is amenable to exon 53 skipping
   - Baseline renal function tests (i.e., glomerular filtration rate [GFR])

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Duchenne Muscular Dystrophy (DMD) Products – Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

1. What is the member's weight? ____ lbs or ___ kg
2. Is the requested drug being prescribed by or in consultation with a pediatric/adult neurologist or a physician who is an expert in the treatment of DMD or other neuromuscular disorders? □ **Yes or** □ **No**
3. Will the member use golodirsen (Vyondys 53®) together with viltolarsen (Viltepso®)? □ **Yes or** □ **No**
4. Does member demonstrate positive clinical response to therapy (such as improvement and/or stabilization compared to baseline) based on updated chart notes? □ **Yes or** □ **No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**