



**NC DHB Request for Prior Approval Exondys 51**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI#: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

**Drug Information**

8. Med requested EXONDYS 51 9a. Strength: \_\_\_\_\_ 9b. Quantity per 30 days: \_\_\_\_\_

9c. Requested Duration (up to 6 months) \_\_\_\_\_ 9d. Beneficiary's weight: \_\_\_\_\_

10. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy? **YES\_NO** \_\_\_\_\_

11. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 51 skipping? **YES\_NO** \_\_\_\_\_

12. Is **Exondys 51** being prescribed by or in consultation with a neurologist? **YES\_NO** \_\_\_\_\_

13. Is the beneficiary taking any other RNA antisense agent or any other gene therapy? **YES\_NO** \_\_\_\_\_

14. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week? **YES\_NO** \_\_\_\_\_

**For PA renewal**

15. Is documentation attached that shows the beneficiary:

a. Has shown an improvement in dystrophin levels **or**

b. Is not ventilator dependent **or**

c. Has some functional use of upper extremities **or**

d. Has an ability to walk with or without assistive devices **YES\_NO** \_\_\_\_\_

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber signature mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to NC Tracks at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505**