



Exondys 51® (eteplirsen) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: **1-866-752-7021 (TTY: 711)**

FAX: **1-888-267-3277**

For Medicare Advantage Part B:

Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Neurologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: (Patient selected choice) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Exondys 51 (eteplirsen) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____
☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

☐ Yes ☐ No Does the patient have a documented diagnosis of Duchenne muscular dystrophy (DMD)?
☐ Yes ☐ No Is the requested drug prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD)?
☐ Yes ☐ No Does the patient's dose exceed 30 mg/kg once weekly?

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Phone: **1-866-752-7021** (TTY: **711**)

FAX: **1-888-267-3277**

For Medicare Advantage Part B:

Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Initial Requests (clinical documentation required):

- ☐ Yes ☐ No Was genetic testing conducted to confirm the diagnosis of Duchenne muscular dystrophy (DMD)?
- ☐ Yes ☐ No Was genetic testing conducted to identify the specific type of DMD gene mutation?
- Please indicate the DMD gene mutation: _____
- ☐ Yes ☐ No Is the DMD gene mutation amenable to exon 51 skipping?
- ☐ Yes ☐ No Is the patient able to achieve an average distance of at least 180 meters while walking independently over 6 minutes?
- ☐ Yes ☐ No Will treatment with the requested drug be initiated prior to age 14?
- ☐ Yes ☐ No Has the patient previously received gene replacement therapy for DMD (e.g., Elevidys)?
- ☐ Yes ☐ No Has the patient experienced a worsening in clinical status (e.g., decline in ambulatory function) since receiving gene replacement therapy for DMD (e.g., Elevidys)?

For patients re-starting therapy with the requested drug after administration of gene therapy (clinical documentation required):

- ☐ Yes ☐ No Was genetic testing conducted to confirm the diagnosis of Duchenne muscular dystrophy (DMD)?
- ☐ Yes ☐ No Was genetic testing conducted to identify the specific type of DMD gene mutation?
- Please indicate the DMD gene mutation: _____
- ☐ Yes ☐ No Is the DMD gene mutation amenable to exon 51 skipping?
- ☐ Yes ☐ No Is the patient able to achieve an average distance of at least 180 meters while walking independently over 6 minutes?
- ☐ Yes ☐ No Will treatment with the requested drug be initiated prior to age 14?
- ☐ Yes ☐ No Has the patient experienced a worsening in clinical status (e.g., decline in ambulatory function) since receiving gene replacement therapy for DMD (e.g., Elevidys)?

For Continuation Requests (clinical documentation required):

- ☐ Yes ☐ No Has the patient demonstrated a response to therapy as evidenced by remaining ambulatory (e.g., able to walk with or without assistance, not wheelchair dependent)?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.