Exondys 51 (eteplirsen)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Exondys 51 100mg/2ml vial ☐ Exondys 51 500mg/10ml vial

Dose: Frequency of therapy: Duration of therapy:

ICD10: What is your patient's current weight?

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Duchenne muscular dystrophy
☐ All other indications

Clinical Information:

Is documentation being provided that prior to initiation with Exondys 51, does/did the patient have a confirmed pathogenic or likely pathogenic variant of the DMD gene that is amenable to exon 51 skipping? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Prior to initiation with Exondys 51, is/was your patient able to walk a distance of at least 180 meters independently over 6 minutes (6MWT)? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with, a neurologist or neuromuscular specialist, or by a Muscular Dystrophy Association (MDA) Care Center? ☐ Yes ☐ No

Will the requested medication be used concurrently with other exon-skipping DMD agents (for example, Amondys 45, Viltepso, Vyondys 53)? ☐ Yes ☐ No

Is this a request for initial therapy or is the patient currently receiving the medication?
☐ Initial therapy
☐ Currently Receiving

(if currently receiving) Has the patient experienced a beneficial clinical response, including the continued ability to walk? ☐ Yes ☐ No

(if currently receiving) Was the patient less than 14 years of age when they started therapy? ☐ Yes ☐ No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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