



Amondys 45

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Site of Service Questions:

- A. Where will this drug be administered?
- | | |
|---|---|
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Home infusion, <i>skip to Criteria Questions</i> |
| <input type="checkbox"/> Off-campus Outpatient Hospital | <input type="checkbox"/> On-campus Outpatient Hospital |
| <input type="checkbox"/> Physician office, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Criteria Questions</i> |
- B. Is this request to continue previously established treatment with the requested medication?
- Yes This is a continuation of an existing treatment.
- No This is a new therapy request (patient has not received requested medication in the last 6 months).
skip to Criteria Questions
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.**
- Yes, *skip to Criteria Questions* No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Amondys 45 SGM 4563-A - 10.2022.

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- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.** Yes, skip to Criteria Questions No
- E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.** Yes, skip to Criteria Questions No
- F. 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? **ACTION REQUIRED: If Yes, please attach supporting clinical documentation.** Yes No

Criteria Questions:

1. What is the prescribed dose and frequency?
 Amondys 45 50mg/mL Quantity and Frequency: _____
 Other: _____ Quantity and Frequency: _____
2. What is the diagnosis?
 Duchenne muscular dystrophy
 Other _____
3. What is the ICD-10 code? _____
4. What is the patient's weight? _____ kg or lbs (*Circle one*)
5. Is the requested drug prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy? Yes No
6. Is this a request for continuation of therapy with the requested drug? Yes No *If No, skip to #9*
7. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #9* Unknown Yes No
8. 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)? **ACTION REQUIRED: If Yes, attach documentation (e.g., chart notes) of response to therapy.** Yes No *No further questions*
9. Was genetic testing conducted to confirm the diagnosis of Duchenne muscular dystrophy? Yes No
10. Was genetic testing conducted to identify the specific type of DMD gene mutation? **ACTION REQUIRED: If Yes, attach a copy of the genetic testing results.** Yes No
11. Please indicate the DMD gene mutation: _____
12. Is the DMD gene mutation amenable to exon 45 skipping? Yes No
13. Is the patient able to achieve an average distance of at least 300 meters while walking independently over 6 minutes? Yes No
14. Will treatment with the requested drug be initiated prior to age 14? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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