



Nevada Medicaid – Molina Healthcare

Exondys 51™ Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Duchenne Muscular Dystrophy (DMD) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Clinical Information: Is there documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication prescribed by or in consultation with a neurologist who has experience treating children? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the prescribed dose exceed 30 mg/kg of body weight once weekly? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reauthorization: If this is a reauthorization request, answer the following questions: Has the recipient experienced a clinically significant benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the recipient tolerating therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication prescribed by or in consultation with a neurologist who has experience treating children? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the prescribed dose exceed 30 mg/kg of body weight once weekly? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the recipient been on therapy for 12 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , answer the following: Has the recipient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call (833) 685-2103.
 This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
 Office use only: Exondys51_NevadaMedicaid_2018Feb-W