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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Duchenne Muscular Dystrophy (DMD)

❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Is there documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping? ☐ **Yes** ☐ **No**

Is the medication prescribed by or in consultation with a neurologist who has experience treating children? ☐ **Yes** ☐ **No**

Does the prescribed dose exceed 30 mg/kg of body weight once weekly? ☐ **Yes** ☐ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Has the recipient experienced a clinically significant benefit? ☐ **Yes** ☐ **No**

Is the recipient tolerating therapy? ☐ **Yes** ☐ **No**

Is the medication prescribed by or in consultation with a neurologist who has experience treating children? ☐ **Yes** ☐ **No**

Does the prescribed dose exceed 30 mg/kg of body weight once weekly? ☐ **Yes** ☐ **No**

Has the recipient been on therapy for 12 months or more? ☐ **Yes** ☐ **No**

If **Yes**, answer the following:

Has the recipient experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)? ☐ **Yes** ☐ **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.

Office use only: Exondys51_NevadaMedicaid_2018Feb-W