WellCare
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NC Medicaid and NC Health Choice Pharmacy Prior Approval Request
Medications for Duchenne's Muscular Dystrophy - Vyondys 53 and Viltepso

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For initial authorization requests: (please answer questions 1-11)
1. What is the beneficiary's weight? _____
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy? ☐ **Yes** ☐ **No**
3. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 53 skipping? ☐ **Yes** ☐ **No**
4. Is Vyvondys 53/Viltepso being prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**
5. Does the beneficiary have meaningful voluntary motor function? ☐ **Yes** ☐ **No**
6. Has the beneficiary been assessed for any physical therapy and/or occupational therapy needs? ☐ **Yes** ☐ **No**
7. Has the beneficiary's serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio been measured prior to the start of therapy? ☐ **Yes** ☐ **No**
8. Does the prescriber attest that the beneficiary's serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio will be measured during treatment (monthly urine dipstick with serum cystatin C and urine protein-to-creatinine ratio every 3 months)? ☐ **Yes** ☐ **No**
9. Is there documentation of baseline movement/functional testing? ☐ **Yes** ☐ **No**
10. Is the beneficiary taking any other RNA antisense agent or any other gene therapy? ☐ **Yes** ☐ **No**
11. Is the beneficiary receiving a dose that does not exceed 30mg/kg once per week (Vyvondys 53) or 80mg/kg once per week (Viltepso)? ☐ **Yes** ☐ **No**

For reauthorization: (please answer questions 1-13)
12. Please attach documentation that shows the beneficiary has demonstrated a response to therapy compared to pretreatment baseline.
13. Has the beneficiary experienced any treatment-restricting adverse effects? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Please fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**