Member Name: ____________________________ Member ID: _______________ Member DOB: _______________

Drug Name: _____________________________ Strength: ______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: ________________________ Specialty: _____________________

Physician Fax#: ____________________ Pharmacy Name: ___________________________ Pharmacy Phone: _________________

Horizon NJ Health

Golodirsen (Vyondys 53) – Medical Necessity Request

Complete page 1 for initial request and page 2 for subsequent

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Duchenne Muscular Dystrophy (DMD)

Please send in medical records (such as genetic testing, labs) confirming mutation of the DMD gene that is amenable to exon 53 skipping and baseline renal function tests (i.e. glomerular filtration rate [GFR]).

□ Other, please specify ____

General Questions:

1. Is this being prescribed by or in consultation with a pediatric/adult neurologist or a physician who is an expert in the treatment of DMD or other neuromuscular disorders?
   □ Yes □No ____________________________

2. Has the member been receiving systemic corticosteroid therapy? **Yes or No**
   If Yes, please provide name of medications____
   Dates filled____
   Pharmacy name: ____
   Pharmacy phone number and answer #6: ____
   Please send in the documentation (such as pharmacy receipts, pharmacy claims)
   If discontinued please provide reason discontinued: ____
   Please send in the documentation for reason discontinued (such as chart notes)

   If No, Can member try systemic corticosteroid (e.g. prednisone, methylprednisolone, dexamethasone, etc.)? **Yes** or **No**
   If yes, please call the pharmacy, then return form to HNJH
   If no, please provide clinical reason why not? ____
   Please send in the documentation (such as copy of chart or lab data) regarding why member cannot take corticosteroid

3. If the member is receiving systemic corticosteroid, has the member been stable on it? **Yes or No**
   If No, please provide clinical reason why not? ____
   If Yes, please provide how many weeks the member has been stable on systemic corticosteroid therapy. _________________
   Please send in the documentation (such as copy of chart or lab data) regarding why member is not stable on corticosteroid

4. Does the prescriber understand that continued approval of this indication may be contingent upon verification of a clinical benefit in confirmatory trials? **Yes or No**

5. Will member's kidney function be evaluated every 3 months? **Yes or No**

6. What is the member's current weight? _______lbs or _______Kg

Physician office's signature*________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

****Complete page 2 only for Subsequent/Renewal requests****

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Duchenne Muscular Dystrophy (DMD)

1. Is this being prescribed by or in consultation with a pediatric/adult neurologist or a physician who is an expert in the treatment of DMD or other neuromuscular disorders?
   □ Yes □ No ______________________________
2. Does the prescriber have updated chart notes demonstrating positive clinical response to therapy? **Yes or No**
3. What is the member's current weight? ______lbs or _________Kg

□ Other:____________________________________

Physician office's signature*________________________________ Print Name_______________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**