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

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

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

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

Horizon NJ Health

Eteplirsen (Exondys 51) – Medical Necessity Request

Complete page 1 for initial request and page 2 for subsequent

<u>Diagnosis Information</u> <u>(please indicate diagnosis and answer related questions):</u>

□ Duchenne Muscular Dystrophy (DMD)

Please send in the documentation (such as genetic testing, labs) confirming mutation of the DMD gene that is amenable to exon 51 skipping

□ Other, please specify ____

General Questions:

1. What is the specialty of the prescriber?

   □ Neurologist □ Other ___________________________________

2. Has the member been receiving systemic corticosteroid therapy? **Yes or No**

   If Yes, please provide name of medications____
   Strength____
   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: ____
   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? ____
   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? ____
   Please send in the documentation (such as copy of chart or lab data) regarding why is not stable on corticosteroid

4. What is the member's current weight? _______lbs or _______Kg Date Taken: __________________

*Weight must be from within the past 30 days.

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. What is the member's current weight? ______lbs or _________Kg Date Taken: __________________

   *Weight must be from within the past 30 days.

Physician office's signature*________________________________ Print Name________________________________

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