Horizon NJ Health
Eteplirsen (Exondys 51) – 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 51 skipping

☐ 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________________________________________
   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: ________________

Physician office's signature* ___________________________ Print Name ___________________________
*Form must be completed and signed by physician or licensed representative from the physician’s office
**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. What is the member’s current weight? _____ lbs or ______ Kg  
     Date Taken: ________________

- Other: __________________________

Physician office's signature*  
Print Name ____________________________

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