

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***

**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

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. 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