



Viltepso

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Site of Service Questions:

- A. Where will this drug be administered?
- | | |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Home infusion, <i>skip to Clinical Questions</i> |
| <input type="checkbox"/> Off-campus Outpatient Hospital | <input type="checkbox"/> On-campus Outpatient Hospital |
| <input type="checkbox"/> Physician office, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Clinical Questions</i> |
- B. Is this request to continue previously established treatment with the requested medication?
- Yes - This is a continuation of an existing treatment.
- No - This is a new therapy request (patient has not received requested medication in the last 6 months). *skip to Clinical Criteria Questions*
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? **ACTION REQUIRED: Attach supporting clinical documentation.**
- Yes, *skip to Clinical Criteria Questions* No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Viltepso SOC SGM -08/2021.

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- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? **ACTION REQUIRED: Attach supporting clinical documentation.** Yes, skip to Clinical Criteria Questions No
- E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? **ACTION REQUIRED: Attach supporting clinical documentation.** Yes, skip to Clinical Criteria Questions No
- F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? **ACTION REQUIRED: Attach supporting clinical documentation.** Yes No

Clinical Criteria Questions:

1. What is the diagnosis? Duchenne muscular dystrophy Other _____
2. What is the ICD-10 code? _____
3. Is the requested drug prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy? Yes No
4. Will the requested medication be used concomitantly with golodiresen (Vyondys 53)? Yes No
5. What is the prescribed dose and patient's weight? **Dose:** _____ mg/kg **Weight:** _____ kg
6. Is this a request for continuation of therapy with the requested drug? Yes No *If No, skip to #8*
7. Has the patient demonstrated a response to therapy as evidenced by remaining ambulatory (e.g., not wheelchair dependent)? **ACTION REQUIRED: If Yes, attach documentation (e.g., chart notes) of response to therapy.** Yes No *No further questions*
8. Was genetic testing conducted to confirm the diagnosis of Duchenne muscular dystrophy? Yes No
9. Was genetic testing conducted to identify the specific type of DMD gene mutation? **ACTION REQUIRED: If Yes, attach a copy of the genetic testing results.** Yes No
10. Please indicate the DMD gene mutation: _____
11. Is the DMD gene mutation amenable to exon 53 skipping? Yes No
12. Is the patient able to walk independently without assistive devices? Yes No
13. Will treatment with the requested drug be initiated prior to age 10? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature

Date (mm/dd/yy)

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