pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

DUCHENNE MUSCULAR DYSTROPHY (DMD) ANTISENSE OLIGONUCLEOTIDES

PRIOR AUTHORIZATION FORM *(form effective 9/18/2023)*

Prior authorization guidelines for DMD Antisense Oligonucleotides are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength & package size:	
Quantity:	Refills:	Beneficiary weight (kg):	
Directions:			
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the requested medication prescribed by or in consultation with a neurologist with experience treating DMD?		☐Yes ☐No	*Submit documentation of consultation with specialist, if applicable.*
Will the beneficiary be using corticosteroids in addition to the requested medication, or does the beneficiary have a history of intolerance or contraindication to corticosteroids?		☐Yes ☐No	*Submit complete medication list.*
INITIAL Requests			
Is the requested medication being used to treat a diagnosis that is included in the FDA-approved package labeling or supported by medical literature or compendia?		☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested for the beneficiary's diagnosis.*	
Did the beneficiary have a baseline evaluation, including a standardized assessment of motor function, by a neurologist with experience treating DMD?		☐Yes ☐No	*Submit documentation of baseline evaluation and assessment.*
RENEWAL Requests			
Did the beneficiary have an annual evaluation, including a standardized assessment of motor function, by a neurologist with experience treating DMD?		☐Yes ☐No	*Submit documentation of annual evaluation and assessment.*

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Is the beneficiary experiencing clinical benefit from the requested medication?	☐ Yes ☐ No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: