



FLORIDA MEDICAID PRIOR AUTHORIZATION

Exondys 51® (eteplirsen)

(Note: Maximum Length of Approval is 6 Months)

Note: Form must be completed in full.

An incomplete form may be returned.

Recipient's Medicaid ID#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Table with columns: MEDICATION, QUANTITY, DIRECTIONS. Includes fields for Weight, Diagnosis, Provider Specialty, and Therapy type (Initiation/Continuation).

NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST. FORM AND LAB DATA MUST BE COMPLETED IN FULL.

Official Genetic Testing Confirming Diagnosis: Yes/No, Date of Test

Six-Minute Walk Test: Yes/No, Date of Test

Brooke Upper Extremity Function Scale: Yes/No, Date

Forced Vital Capacity: Yes/No, Date

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to: Magellan Medicaid Administration, Inc. Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078

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