

Date: _____ Date Medication Required: _____
 Ship to: Physician Patient's Home Other: _____



Health Net Health Plan of Oregon, Inc.
 Health Net Life Insurance Company
 Prior Authorization / Formulary Exception Request Fax Form
 FAX TO: (800) 255-9198

Form must be fully completed to avoid a processing delay.

For status of a request, call: (888) 802-7001

Patient Information

Last Name:		First Name:		Middle:	DOB: ___/___/___	
Address:				City:		State: Zip:
Daytime Phone:			Evening Phone:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Insurance Information (Attach copies of cards)

Primary Insurance:		Secondary Insurance:			
ID #	Group #	ID #	Group #		
City:		State:	City:		State:

Physician Information

Name:		Specialty:		NPI:	
Address:			City:		State: Zip:
Phone #:		Secure Fax #:		Office Contact:	

Primary Diagnosis

ICD-10 Code: _____
 Duchenne muscular dystrophy (DMD) Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Exondys 51 (eteplirsen)				

Clinical Information ***** Please submit supporting clinical documentation *****

INITIAL THERAPY CONTINUATION OF THERAPY; Therapy start date: _____

- Has patient had a positive response to the prescribed therapy within the last 30 days?
 Yes **Mark all that apply** No Not applicable
 - Ambulatory function with a 6 minute walk test distance (6MWT) ≥ 200m? Yes: _____ m No
 - Stable cardiac function with left ventricular ejection fraction (LVEF) > 40%? Yes: _____ % No
 - Stable pulmonary function with predicted forced vital capacity (FCV) ≥ 50%? Yes: _____ % No
 - Other: _____
- Is Exondys 51 prescribed concurrently with an oral corticosteroid?
 Yes: _____ No No, contraindicated/intolerant
- Is Exondys 51 prescribed concurrently with other exon-skipping therapies (e.g., Vyondys 53)? Yes: _____ No

Please continue to page 2

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Eteplirsen (Exondys 51)

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Complete this section ONLY if the patient is initiating therapy OR if the patient is new to this health plan:

- 4. Is therapy prescribed by or in consultation with a neurologist? Yes No
- 5. **If DMD**, is mutation amenable to exon 51 skipping confirmed with genetic testing? Yes, mutation: _____ - _____ No
- 6. Has the patient had an inadequate response (evidenced by significant decline in 6MWT, LVEF, OR FVC) despite adherent use of an oral corticosteroid (e.g., prednisone, Emflaza) for ≥ 6 months? Yes No No, contraindicated/intolerant

Complete this section ONLY for indications other than DMD:

- 7. Has patient tried and failed, or is contraindicated to, accepted standards of care? Yes No

If yes, submit documentation and answer the following:

- a. Please list all previous therapies: _____
- b. Was patient adherent to previously tried therapies? Yes No No, patient intolerant to drug

Physician's Signature: _____ Date: _____ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

Authorization Information

Authorization number:	Decision Due Date:
J-Code:	Coverage: <input checked="" type="checkbox"/> State excludes <input checked="" type="checkbox"/> COB (secondary)
Line of Business: <input type="checkbox"/> Commercial <input type="checkbox"/> Health Insurance Marketplace <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare (CY2019/20 Carved out)	Benefit: <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy
Criteria: <input type="checkbox"/> Centene Policy Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____ <input type="checkbox"/> State Specific (please include policy)	
Medicare only: <input type="checkbox"/> PART B use LCD or NCD <input type="checkbox"/> PART D use MCPD.PA.247 Tier and Formulary Exceptions Request Criteria	