aetna®

Exondys51® (Eteplirsen) Injectable Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Exondys51: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests:

☐ Yes ☐ No Does the patient have a documented diagnosis of Duchenne muscular dystrophy (DMD)?
☐ Yes ☐ No Does the patient have a dystrophin gene mutation?
→ ☐ Yes ☐ No Is the dystophin gene mutation amenable to exon 51 skipping?
☐ Yes ☐ No Has genetic testing been completed to confirm the diagnosis?
→ Which of the following genetic tests have been completed to confirm the diagnosis?
☐ Multiplex PCR ☐ Southern Blot ☐ MLPA (Multiple Ligation-dependent Probe Amplification)
☐ CHG Array (Comparative Genomic Hybridization Array) ☐ Stranger Gene Sequencing
☐ MAPH (Multiplex Amplifiable Probe Hybridization) ☐ SCAIP (Single Condition Amplification/ Internal Primer)
☐ mRNA analysis/ cDNA sequencing ☐ Resequencing Array ☐ Other-Explain: _____
Please enter the date genetic testing was completed. Date: ____/____/____
Please enter the findings of the genetic testing: _____

☐ Yes ☐ No Is the patient receiving care or consultation with a physician who specializes in treatment of DMD?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?
☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: _____
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?
☐ Yes ☐ No Does the patient have documentation of unstable vascular access?
☐ Yes ☐ No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?
→ Please explain: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For All requests continued:

☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?

→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?

→ Please document the following:
- ☐ GFR:_____ mL/min/1.73m^2 Date Collected: ____/____/____
- ☐ BUN:_____ mg/dL Date Collected: ____/____/____
- ☐ Creatinine:_____ mg/dL Date Collected: ____/____/____

For Initial Requests:

What is the average distance the patient is able to walk independently over a six minute time period?

☐ 0- 90 meters ☐ 91- 179 meters ☐ 180 meters or greater

For Continuation Requests:

At what age was eteplirsen initiated? _____

☐ Yes ☐ No Has the patient demonstrated an adequate response to therapy?

☐ Yes ☐ No Has the patient remained ambulatory?

→ Please identify: ☐ Able to walk **without** assistance ☐ Able to walk **with** assistance ☐ Wheelchair bound

☐ Yes ☐ No Has the patient received eteplirsen within the past 6 months?

→ ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?

→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.