Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Duchenne Muscular Dystrophy: Vyondys 53 and Viltepso

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For initial and re-authorization requests: (please answer questions 1-11)

1. What is the member's weight? _____
2. Does the member have a diagnosis of Duchenne Muscular Dystrophy? ☐ **Yes** ☐ **No**
3. Are medical records attached to this request that confirm the mutation of the Duchenne Muscular Dystrophy gene is amenable to exon 53 skipping? ☐ **Yes** ☐ **No**
4. Is Vyondys 53/Viltepso being prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**
5. Does the member have meaningful voluntary motor function? ☐ **Yes** ☐ **No**
6. Has the member been assessed for any physical therapy and/or occupational therapy needs? ☐ **Yes** ☐ **No**
7. Has the member's serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio been measured prior to the start of therapy? ☐ **Yes** ☐ **No**
8. Does the prescriber attest that the member's serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio will be measured during treatment (monthly urine dipstick with serum cystatin C and urine protein-to-creatinine ratio every 3 months)? ☐ **Yes** ☐ **No**
9. Is there documentation of baseline movement/functional testing? ☐ **Yes** ☐ **No**
10. Is the member taking any other RNA antisense agent or any other gene therapy? ☐ **Yes** ☐ **No**
11. Is the member receiving a dose that does not exceed 30mg/kg once per week for (Vyondys 53) or 80mg/kg once per week (Viltepso)? ☐ **Yes** ☐ **No**

For reauthorization: (please answer questions 12 &13)

12. Please attach documentation that shows the member has demonstrated a response to therapy compared to pretreatment baseline.
13. Has the member experienced any treatment-restricting adverse effects? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277