Washington State Health Care Authority

Clear Form

Exondys 51 (eteplirsen)

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.
Without this information, we may deny the request in 30 days.

DATE OF REQUEST	PATIENT	DATE OF BIRTH	PROVIDERONE CLIENT ID

PRESCRIBER	BILLING PROVIDER NPI NUMBER	TELEPHONE NUMBER	FAX NUMBER

DRUG/STRENGTH/DOSE

1. What is patient's diagnosis:

   Date of diagnosis:

2. What is patient's most current weight:
   Date weight was taken:

Attach all of the following required documentation with your request:

- Results of motor functional tests prior to starting Exondys 51 AND the most recent numerical data from other outcome measures: (please provide quantitative data and not qualitative descriptions for this section)
  - Required:
    - 6 minute walk test: _____
      AND
    - North Star Ambulatory Assessment: _____
  - Optional:
    - Rise time velocity: _____
    - Run time velocity: _____
    - 10 meter run time: _____
- Results of genetic test confirming Duchenne Muscular Dystrophy amenable to exon 51 skipping
- Dose and duration of corticosteroid therapy
- Most recent pulmonary function test (FEV1%; FEV1/FVC)
- Chart notes

PRESCRIBER'S SIGNATURE	PRESCRIBER'S SPECIALTY	DATE

A typed and completed *General Authorization for Information* form (13-835) must be attached to your request and must be the first page (no cover sheet).

Fax to: **1-866-668-1214**