Aetna Better Health® of Florida (MEDICAID)

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#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

MEDICATION	QUANTITY	DIRECTIONS

Weight _____ **lbs or** _____ **kgs as of** _____ **(date)**

Diagnosis _____

Provider Specialty _____

☐ **Initiation of Therapy** **OR** ☐ **Continuation of Therapy**

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.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.