



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Table with columns: MEDICATION, QUANTITY, DIRECTIONS. Includes fields for Weight, Diagnosis, Provider Specialty, and checkboxes for Initiation/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.

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