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United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

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 this form to 1-866-940-7328

Pharmacy PA Call Center:

1-855-258-1593

02.15.2024