



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** 1-877-208-7428      **Phone:** 1-800-745-7318

## Neuromuscular Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### Member information

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 MassHealth member ID # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Gender (Check one.)  F  M      Member's place of residence  home  nursing facility

### Medication information

#### Medication requested

Exondys 51 (eteplirsen)       Spinraza (nusinersen)

**Dose, frequency, and duration of medication requested** \_\_\_\_\_

#### Indication

Duchenne muscular dystrophy (DMD)       Spinal muscular atrophy (SMA)  
 Other \_\_\_\_\_ Type \_\_\_\_\_

Please indicate whether the request is for pharmacy or in-office billing.  Pharmacy billing  In-office billing  
 Is the member stabilized on the requested medication?  Yes. Please provide start date. \_\_\_\_\_  No.

### Section I. Please complete for Exondys 51 requests.

For initial requests, please complete questions 1 through 7. For continuation of therapy requests, please complete questions 1, 6, 8 and 9.

- Member's current weight \_\_\_\_\_ Date \_\_\_\_\_
- Please attach laboratory testing results of a confirmed out-of-frame deletion in the DMD gene that is amenable to exon 51 skipping.
- Is the prescriber a neuromuscular neurologist?  Yes  No. If no, please attach consultation notes from a neuromuscular neurologist addressing the use of the requested agent.
- Is the member ambulatory as defined by a current six-minute walk test (6MWT-distance walked in six minutes in meters) of  $\geq 200$  meters?  
 Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.  
 Yes. Distance \_\_\_\_\_ meters  No  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Has the member received a corticosteroid for at least six months prior to use with the requested agent?  
 Yes. Please list the drug name, dose and frequency, and dates of use below.  
 Drug name \_\_\_\_\_ Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_

- No. Please explain \_\_\_\_\_
6. Will the member be taking the requested agent concurrently with a corticosteroid?
- Yes. Please document drug name with dose and frequency below.  
 Drug name \_\_\_\_\_ Dose and frequency \_\_\_\_\_
- No. Please explain \_\_\_\_\_
7. Please provide dates and measurements and attach medical records of baseline measurements for each of the following five timed function tests: timed 10-meter walk/run, timed floor (supine) to stand, timed four-step descend, timed four-step climb, timed sit to stand. Medical records must include the times in seconds, dates of performances, and treatment at the time of tests. Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
- Timed 10-meter walk/run (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed floor (supine) to stand (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed four-step descend (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed four-step climb (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed sit to stand (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
8. Please provide dates and measurements and attach medical records of all previous and current six-minute walk tests (6MWTs). Please note, the current test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
- Baseline 6MWT  
 Distance \_\_\_\_\_ meters  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Current 6MWT  
 Distance \_\_\_\_\_ meters  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Additional 6MWT(s)  
 Date(s) of performance \_\_\_\_\_
9. Please provide dates and measurements and attach medical records of current measurements for each of the following five timed function tests: timed 10-meter walk/run, timed floor (supine) to stand, timed four-step descend, timed four-step climb, timed sit to stand. Medical records must include the times in seconds, dates of performances, and treatment at the time of tests. Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
- Timed 10-meter walk/run (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed floor (supine) to stand (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed four-step descend (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed four-step climb (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_
- Timed sit to stand (time in seconds) \_\_\_\_\_  
 Date of performance \_\_\_\_\_ Treatment at the time of test \_\_\_\_\_

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**Section II. Please complete for Spinraza requests.**

1. Please attach a copy of genetic test confirming diagnosis of SMA.
2. Is the prescriber a neurologist?  Yes  No. If no, please attach consultation notes from a neurologist addressing the use of the requested agent.
3. Please attach documentation of baseline motor function test.

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**Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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**Prescriber information**

Last name\* \_\_\_\_\_ First name\* \_\_\_\_\_ MI \_\_\_\_\_  
NPI\* \_\_\_\_\_ Individual MH Provider ID \_\_\_\_\_  
DEA No. \_\_\_\_\_ Office Contact Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Telephone No.\* \_\_\_\_\_ Fax No.\* \_\_\_\_\_

\* *Required*

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**Prescribing provider's attestation, signature, and date**

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

**Signature required** \_\_\_\_\_  
Printed name of prescribing provider \_\_\_\_\_ Date \_\_\_\_\_