South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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PIERRE, SD 57501-22941

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VONDYS 53 PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA		
☐	**Medical records to support use of product are submitted**	
Initial Therapy (check one)	**Yes** ☐	**No** ☐
☐	Prescribed by or in consultation with provider in neurology with expertise in neuromuscular disorders	
☐	Individual must have a diagnosis of DMD with documentation of confirmed mutation that DMD gene is amenable to exon 53 skipping (submission of medical records, genetic testing, etc.)	
☐	If ambulatory, documentation of baseline 6-minute walk or NorthStar Ambulatory Assessment no longer than one month prior to beginning Vondys 53	
☐	If non-ambulatory, baseline functional level assessment with **all** the following is required, no longer than one month prior to beginning Vondys 53 ☐ Brooke upper extremity scale (≤ 5) ☐ Forced vital capacity assessment (of ≥30%) ☐ Stable cardiac function with left ventricular ejection fraction (LVEF) > 40%	
☐	Individual is not ventilator dependent	
☐	Therapy is not being used in conjunction with other exon skipping therapies for DMD (ie Exondys 51, Amondys 45, Viltepso)	
☐	Therapy is initiated before the age of 14	
☐	Individual has been on a stable dose of corticosteroids for 6 months unless contraindicated or adverse effects were previously experienced	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Must continue to meet all initial criteria	
☐	Continued follow-up with neurology provider and/or neuromuscular clinic	
☐	Documentation of response to therapy is recorded every 6 months and shows stability or improvement in **both** of the following: ☐ 6-minute walk or NorthStar Ambulatory Assessment ☐ Respiratory function	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form must be signed by a provider		
☐	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		**Specialty:**
Signature:		