Clinical Criteria Worksheet:
Duchenne Muscular Dystrophy (DMD) Drug

Enrollee Information

Enrollee Last Name: _____

Enrollee First Name: _____

Date of Birth (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): ☐☐☐☐☐☐☐☐☐

Address: _____

City, Town or Post Office: _____ **State:** _____ **ZIP Code:** _____

Prescriber Information

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Preferred Contact (Telephone Number): _____

Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Enrollee Last Name: **Enrollee First Name:**

_____ _____

Drug Name and Strength:

☐ casimersen (AMONDYS 45™)

☐ eteplirsen (EXONDYS 51™)

☐ viltolarsen (VILTEPSO®)

☐ golodirsen (VYONDYS 53™)

☐ other DMD drug (unclassified code J3490)

Strength: _____ **Directions:**_____

Quantity: _____

New Treatment: ☐ Yes ☐ No

If **No**, date therapy initiated: _____

Clinical Criteria – Diagnosis

1. ☐ Duchenne Muscular Dystrophy

   ☐ Other: _____

2. Is the patient currently being treated with another exon skipping therapy for DMD?

   ☐ Yes ☐ No

If this is a continuation of therapy for the patient and you have already received payment for previous administration for this medication, provide attestation signature on page 3. Additional information on page 3 is not necessary.

For diagnosis of Duchenne Muscular Dystrophy:

3. Does the patient have documented genetic testing confirming the mutation of the DMD gene is amendable to exon 45, 51, or 53 skipping?

   ☐ Yes ☐ No

4. If **Yes**, please provide the date of the lab test result:

   ☐☐ / ☐☐ / ☐☐☐☐

Enrollee Last Name: **Enrollee First Name:**

_____ _____

5. Does the pateint have documented stable dose of corticosteroids prior to starting DMD therapy?

   ☐ Yes ☐ No

   If **Yes**, please provide therapy length:

   Months:_____

   If **No,** please provide rationale for not utilizing a corticosteroid:

   Rationale:_____

6. Does the patient have documented kidney function testing prior to starting therapy? (*skip the question if the administered drug is eteplirsen*)

   ☐ Yes ☐ No

   If **Yes**, please provide the date of the testing (MM/DD/YYYY):

   ☐☐ / ☐☐ / ☐☐☐☐

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

_____ _____

Prescriber Signature (Required) **Date (MM/DD/YYYY)**