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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:
1-800-310-6826

02.01.2025