UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Agamree (vamorolone)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient 2 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by genetic testing, which is included in the submitted chart notes? ❑ **Yes** ❑ **No**
3. Is Agamree being prescribed by or in consultation with a neurologist specializing in the treatment of DMD? ❑ **Yes** ❑ **No**
4. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to prednisone **OR** deflazacort at the maximally tolerated dose for at least 3 months? ❑ **Yes** ❑ **No**
5. Has the patient experienced at least **ONE** of the following unmanageable side effects from either prednisone or deflazacort? ❑ **Yes** ❑ **No**
   - ☐ Abnormal weight gain (e.g., at least a 10% increase in baseline weight over a 3-month period)
     Details: _____
   - ☐ Cushingoid effects
     Details: _____
   - ☐ Psychiatric or behavioral disturbances
     Details:_____
   - ☐ Diabetes and/or hypertension that is difficult to manage per the prescribing provider
     Details: _____
6. Has the provider included at least **ONE** of the following baseline motor scores in the chart notes? ❑ **Yes** ❑ **No**
   - ☐ 6-minute walk test (6MWT)
   - ☐ Time to Stand Test (TTSTAND)
   - ☐ Time to Run/Walk 10 meters (TTRW)

Reauthorization Criteria:

1. Has the provider submitted an updated letter of medical necessity **OR** updated documentation demonstrating positive clinical response to therapy including? ❑ **Yes** ❑ **No**
   - ☐ Slowing of disease progression **OR**
   - ☐ Stabilization or improvement of muscle strength or pulmonary function **OR**
   - ☐ **ONE** of the following motor assessment scores from baseline testing
     - ☐ 6MWT
     - ☐ TTSTAND
     - ☐ TTRW

Initial Authorization: Up to one (1) year
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.