**Claim Submission**

* Claim processing may be delayed if the information submitted in this worksheet is illegible.
* If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
* A claim should not be submitted until the drug has been administered to the patient.
* The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

# Enrollee Information

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Date of Birth (MM/DD/YYYY): Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Address:**

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

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# Prescriber Information

**Prescriber Last Name: Prescriber First Name:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**National Provider Identifier (NPI) Number:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Preferred Contact (Telephone Number)**

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

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# Clinical Criteria – Drug Information

**Drug Administration:**

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

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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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):

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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**.

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

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## 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

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

|  |  |  |  |  |  |  |  |  |  |
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1. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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):

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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# 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) |