

Aetna Better Health® of Florida (MEDICAID)

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											f Birth (MM/DD/YYYY)																	
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Recipient's Full Name																												
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Prescr	Prescriber's Full Name															_												
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Prescr	Prescriber Phone Number												Prescriber Fax Number															
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Weight lbs or											kgs as of (date)																	
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	☐ Initiation of Therapy OR ☐ Continuation of Therapy																											
NOTE: OFFICIAL LAD DEPONTS AND TESTING MUST BE SUBMITTED WITH THE BRICK AUTHORIZATION REQUEST															СТ													
NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST.															51.													
FORM AND LAB DATA MUST BE COMPLETED IN FULL.																												
Offici	Official Genetic Testing Confirming Diagnosis:											Six-Minute Walk Test:																
☐ Yes ☐ No										☐ Yes ☐ I							0											
Date of Test:										Date of Test:																		
Brook	Brooke Upper Extremity Function Scale:												Forced Vital Capacity:															
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Prescriber's Signature:																		Date):									
REQU	IRED I	FOR F	REVII	EW:	All c	opie	s of	medi	ical ı	reco	rds (e.g.,	diag	gnost	tic ev	/alua	tions	and	l rec	ent c	hart	note	es), a	and th	he m	ost r	ecer	nt

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

copies of related labs. The provider must retain copies of all documentation for five years.

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