Mountain Pacific
INNOVATING BETTER HEALTH

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# Montana Healthcare Programs Prior Authorization Request Form for Use of Agamree® (vamorolone)

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|---|---|---|
| Member Name: | DOB: | Date: |
| Member ID: | Prescriber Phone: | |
| Current Member Weight: | Requested Dose: | |
| Prescriber Name/Specialty if applicable: | Prescriber Fax: | |

**Please complete below information for applicable situation, Initiation or Continuation of therapy:**

## ☐ INITIATION OF THERAPY

1. Member is 2 years of age or older: ☐ Yes ☐ No
2. Member has a confirmed diagnosis of DMD (Duchenne Muscular Dystrophy): ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a provider who specializes in the treatment of DMD: ☐ Yes ☐ No

   **Action required**: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   **Name of specialist:** _____ **Contact date:** _____
4. Member has had a trial of prednisone for a minimum of 6 months and has had at least one of the following significant, intolerable adverse effects that is unable to be managed **(CHART NOTES MUST BE PROVIDED THAT POSITIVELY DOCUMENT THE ADVERSE EFFECT)**:

   - ☐ Cushingoid appearance
   - ☐ Central (truncal) obesity
   - ☐ Weight gain of at least 10% of body weight over a 6-month period
   - ☐ Diabetes and/or hypertension that is difficult to manage
   - ☐ Bone fractures in spite of preventative measures (e.g., weight bearing exercises, fall prevention, vitamin D, calcium supplementation, etc.) for bone loss
   - ☐ Has experienced severe behavioral adverse effects while on prednisone therapy that has or would require a prednisone dose reduction

**LIMITATIONS:**
Maximum dose for initial authorization: 6mg/kg up to a maximum of 300mg daily

**Initial authorization will be issued for 6 months.**

## ☐ CONTINUATION OF THERAPY

1. Member has documentation of positive clinical response to therapy compared to other corticosteroids (e.g., reduction in Cushingoid appearance, reduction in the rate of weight gain, etc.). **CHART NOTES MUST BE PROVIDED TO SHOW AN OBJECTIVE BENEFIT.** ☐ Yes ☐ No
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – prescriber is a specialist.

**LIMITATIONS**:
Maximum dose for renewal authorization: 6mg/kg up to a maximum of 300mg daily

**Reauthorization will be issued for 12 months.**

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**Please complete form, including required attachments, and fax to Medicaid Drug Prior Authorization Unit at 1-800-294-1350.**

02/2024