Audience: CC All
Location: Benefits/A-Z List
Updated: 9.29.21

Reviewed: 9.29.21

# Exondys 51 (Eteplirsen)

**Drug names**

1. Eteplirsen
2. Exondys 51™

**Description**

Exondys 51™ (Eteplirsen) is used to treat children with Duchenne muscular dystrophy (DMD). It is not a cure for DMD.

It is administered by intravenous (IV) infusion.

**Commercial**

A Pharmacy Clinical Guideline, *Exondys-51 (Eteplirsen)*, is on Magellan Rx Management.

- **Requires prior authorization through Magellan**. Refer to *Review Criteria*.
  - **Important**: Check policy for limits or exclusions.
  - **ER or inpatient hospital POS**: PA is not required.
  - **Providers**: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.
- Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.
- **DOS prior to 1.1.20**: Considered investigative; not covered.

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**Government Programs**

Refer to the table below.

| Plan | Coverage |
|---|---|
| AccessAbility (SNBC), Minnesota Senior Care Plus (MSC+) | Medicaid only groups:<br>• Refer to Medicaid below.<br><br>Medicare eligible groups:<br>• Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.<br>• Medicare is the primary payer.<br>• Follows Medicare guidelines.<br>• If no Medicare eligibility, Medicaid applies. Refer to Medicaid below. |
| AccessAbility Enhanced (SNBC SNP), DUAL (MSHO) | • A Pharmacy Clinical Guideline, *Exondys-51 (Eteplirsen)*, is on Magellan Rx Management.<br>• **Requires prior authorization through Magellan**. Refer to *Review Criteria*<br>– **Important**: Check policy for limits or exclusions.<br>– **ER or inpatient POS**: PA is not required.<br>– **Providers**: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.<br>• Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.<br>• **DOS prior to 1.1.20**: Considered investigative; not covered.<br>• Medica is the only payer. |

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## Exondys 51 (Eteplirsen), Continued

**Government Programs**, continued

| Plan | Coverage |
|---|---|
| Advantage | • A Pharmacy Clinical Guideline, *Exondys-51 (Eteplirsen)*, is on Magellan Rx Management.<br>• **Requires prior authorization through Magellan**. Refer to *Review Criteria*<br>– **Important**: Check policy for limits or exclusions.<br>– **ER or inpatient POS**: PA is not required.<br>– **Providers**: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.<br>• Professionally administered drugs pull multiple benefits. It is important to quote ALL benefits.<br>– **Administration**: Covered based on place of service. Quote office visit or Home IV Therapy benefits. Check EOC for primary or specialist cost sharing.<br>– **Drug (J-code)**: Covered under *Part B Prescription Drugs* in the EOC.<br>• **DOS prior to 1.1.20**: Considered investigative; not covered.<br>• Provider must bill per Medicare Product Grid.<br>• Medica is the only payer. |

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**Government Programs**, continued

| Plan | Coverage |
|---|---|
| Advantage PartnerCare (I-SNP) | • A Pharmacy Clinical Guideline, *Exondys-51 (Eteplirsen)*, is on Magellan Rx Management.<br>• **Requires prior authorization through Magellan**. Refer to *Review Criteria*<br>– **Important**: Check policy for limits or exclusions.<br>– **ER or inpatient POS**: PA is not required.<br>– **Providers**: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.<br>• Professionally administered drugs pull multiple benefits. It is important to quote ALL benefits.<br>– **Administration**: Covered based on place of service. Quote office visit or Home IV Therapy benefits. Check EOC; copays depend on place of service.<br>– **Drug (J-code)**: Covered under *Part B Prescription Drugs* in the EOC.<br>• Provider must bill per Medicare Product Grid.<br>• Medica is the only payer. |
| Medicaid (SPP) | • A Pharmacy Clinical Guideline, *Exondys-51 (Eteplirsen)*, is on Magellan Rx Management.<br>• **Requires prior authorization through Magellan**. Refer to *Review Criteria*<br>– **Important**: Check policy for limits or exclusions.<br>– **ER or inpatient POS**: PA is not required.<br>– **Providers**: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.<br>• Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.<br>• **DOS prior to 1.1.20**: Considered investigative; not covered. |

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**Government Programs**, continued

| Plan | Coverage |
|---|---|
| Prime | • Professionally administered drugs pull multiple benefits. It is important to quote ALL benefits.<br>– **Administration**: Covered based on place of service. Quote office visit or Home IV Therapy benefits. Check EOC for primary or specialist cost sharing.<br>– **Drug (J-code)**: Covered under *Part B Prescription Drugs* in the EOC.<br>• Follows Medicare guidelines.<br>• Provider must bill per Medicare Product Grid.<br>• **Reminder**: Members can use non-Medica Service Area providers. Refer to Out-of-MSA Benefits. |
| Select, Signature | • Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.<br>• Medicare supplement. Medicare is the primary payer.<br>• Follows Medicare guidelines. |

**Individual and Family Business (IFB)**

A Pharmacy Clinical Guideline, *Exondys-51 (Eteplirsen)*, is on Magellan Rx Management.

- **Requires prior authorization through Magellan**. Refer to *Review Criteria*.
  - **Important**: Check policy for limits or exclusions.
  - **ER or inpatient hospital POS**: PA is not required.
  - **Providers**: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.
- Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.
- **DOS prior to 1.1.20**: Considered investigative; not covered.

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**Medica Health Plan Solutions (MHPS)**

Coverage depends on the employer.

<table>
<tr><th>Employer</th><th>Coverage</th></tr>
<tr><td>Mayo Medical Plan</td><td>Coverage depends on DOS.
<table>
<tr><th>DOS</th><th>Coverage</th></tr>
<tr><td>Effective 10.1.21</td><td>• A Pharmacy Clinical Guideline, Exondys-51 (Eteplirsen), is on Magellan Rx Management.<br>• Requires prior authorization through Magellan. Refer to Review Criteria.<br>– Important: Check policy for limits or exclusions.<br>– ER or inpatient hospital POS: PA is not required.<br>– Providers: All providers, including Mayo Clinic providers, require PA.<br>– Medicare supplement: PA does not apply.<br>• Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.</td></tr>
<tr><td>Prior to 10.1.21</td><td>• Not covered.<br>• This drug is on the Mayo Medical Plan Drug Exclusion List (Non-Covered Drugs).</td></tr>
</table></td></tr>
<tr><td>All others</td><td>• A Pharmacy Clinical Guideline, Exondys-51 (Eteplirsen), is on Magellan Rx Management.<br>• Requires prior authorization through Magellan. Refer to Review Criteria<br>– Important: Check policy for limits or exclusions.<br>– ER or inpatient POS: PA is not required.<br>– Providers: Certain providers are excluded. Refer to Magellan Rx Prior Authorization.<br>• Covered based on place of service. Quote office visit, outpatient hospital, or Home IV Therapy benefits.<br>• DOS prior to 1.1.20: Considered investigative; not covered.</td></tr>
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**Document history**

The document history for the past 12 months is outlined below. See Iris/KN for the complete document history.

| Date | Description |
|---|---|
| 9.29.21 | *MHPS – MMP* – Added eff 10.1.21, policy and PA apply. |
| 1.22.20 | Updated to Magellan policy from investigative Drug policy. |
| 1.22.20 | Updated to new template. |

**Applicability**

| **Business Segments** | | |
|---|---|---|
| ■ All ☐ AHP ☐ COM- (All) ☐ GOVT- (All) ☐ IFB ☐ MHPS ☐ PSC | | |
| **Specific Clients/Products** | | |
| ■ All ☐ Other: | | |
| **Platform or System** | | |
| ☐ All ■ N/A ☐ Other: | | |
| **Departments** | | |
| ■ Call Center ☐ Multiple: ☐ Other: | | |
| **Approved By** | **Document Owner** | **Date** |
| A-Z Review Team | KNTWs | 9.29.21 |