Antisense Oligonucleotide Request Form

Full Name		CCS Case #		Date Completed	
County		Age		Exon 51 Skip Amenable Mutation (Yes/No)	
				Exon 53 Skip Amenable Mutation (Yes/No)	

I. Clinical Baseline

a. BMI/Weight			
b. FVC (Forced Vital Capacity) %		Date Completed	
c. Brooke score		Date Completed	
d. 6MWT (6-minute walk test)		Date Completed	
e. Is patient ambulatory (Yes/No)?	If Yes and 6MWT cannot be done, provide explanation:		
f. Urinalysis shows absence of proteinuria (Y/N)		Date Completed	
g. BUN		Date Completed	
h. Creatinine (when on eteplirsen) or serum cystatin C (when on golodirsen)		Date Completed	
i. Notes			

j. Form Completed By (Name/Title)	k. Special Care Facility Name	l. Date Completed

II. Request For Reauthorization of Antisense Oligonucleotide

a. FVC %		Date Completed	
b. 6MWT		Date Completed	
c. List drug changes after start of Antisense Oligonucleotide treatment			
d. Urinalysis shows absence of proteinuria (Y/N)		Date Completed	
e. BUN		Date Completed	
f. Creatinine (when on eteplirsen) or serum cystatin C (when on golodirsen)		Date Completed	
g. List adverse reactions with Antisense Oligonucleotide treatment			
h. Additional Details			

i. Form Completed By (Name/Title)	j. Special Care Facility Name	k. Date Completed

To be completed by CCS staff

Approved ☐ Denied ☐ Reason for Denial: Date:

Reviewed By (ISCD staff)