Delandistrogene Moxeparvovec-rokl (Elevidys)

Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: __________ Date Medication Required: __________
Ship to: ❍ Physician ❍ Patient's Home ❍ Other __________

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ___/___/_____
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #:	Group #:	ID #:	Group #:

Physician Information

*Name:	*Specialty:	NPI:
*Phone #:	Secure Fax #:	Office Contact:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: ______________________________

☐ Duchenne muscular dystrophy (DMD) ☐ Other: ____________________

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Elevidys (Delandistrogene Moxeparvovec-rokl)				

Clinical Information ***** *Please submit supporting clinical documentation* *****

***THERAPY TYPE (choose one):** ☐ INITIAL THERAPY ☐ CONTINUATION OF THERAPY

Therapy start date: __________

1. Is therapy prescribed by or in consultation with a neurologist? ☐ Yes ☐ No
2. Is patient being treated at a certified Duchenne care center or an MDA care center?
   ☐ Yes, please provide care center name: ______________________________ ☐ No
3. Please provide patient's weight: ____________ kg
4. Is DMD confirmed by genetic testing? ☐ Yes ☐ No
5. Does patient have deletion in exon 8 and/or 9 in the DMD gene? ☐ Yes ☐ No
6. Does patient have ambulatory function as evidenced by a 6-minute walk test (6MWT) distance ≥ 200m within the last 30 days?
   ☐ Yes: ____________ m, date tested: ____________ ☐ No
7. Is there documentation of baseline laboratory test demonstrating anti-AAVrh74 total binding antibody titers < 1:400 as determined by ELISA binding immunoassay? ☐ Yes ☐ No
8. Has patient been on a stable dose of an oral corticosteroid for ≥ 3 months? ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Prednisone ☐ Yes ☐ No ☐ Contraindicated/intolerant
   ☐ Emflaza ☐ Yes ☐ No ☐ Contraindicated/intolerant
   ☐ Other: ____________________ ☐ Yes ☐ No ☐ Contraindicated/intolerant
9. Has patient been previously treated with Elevidys? ☐ Yes ☐ No
10. Is patient currently on exon skipping therapy?
    ☐ Yes* ***Mark all that apply*** ☐ No
    **If yes, provider must submit evidence of clinical deterioration (e.g., significant decline in 6MWT, LVEF, or FVC over a period of 3 to 6 months)*
    ☐ Amondys 45 ☐ Exondys 51 ☐ Viltepso ☐ Vyondys 53 ☐ Other: ____________________
    a. *If yes*, does provider attest of clinical deterioration and discontinuation of exon skipping therapy?
       ☐ Yes ***Submit documentation*** ☐ No

Please continue to page 2.

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Patient Name: ______________________________ **DOB:** ______________

11. Is Delandistrogene Moxeparvovec prescribed concurrently with any of the following? ***Mark all that apply***
    - ☐Amondys 45 ☐Yes ☐No ☐Contraindicated/intolerant
    - ☐Exondys 51 ☐Yes ☐No ☐Contraindicated/intolerant
    - ☐Viltepso ☐Yes ☐No ☐Contraindicated/intolerant
    - ☐Vyondys 53 ☐Yes ☐No ☐Contraindicated/intolerant
    - ☐Oral corticosteroid ☐Yes: ______________ ☐No ☐Contraindicated/intolerant
    - ☐Other ☐Yes: ______________ ☐No ☐Contraindicated/intolerant
12. How many Delandistrogene Moxeparvovec infusion(s) has patient received in their lifetime? ☐0 ☐≥ 1

Complete this section ONLY for indications other than DMD:

13. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
    If yes, submit documentation and answer the following:
    a. Please list all previous therapies: ______________________________
    b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Physician's Signature ______________________________ **Date:** ____________ ☐ **DAW**

INFORMATION BELOW IS TO BE COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

Authorization Information

***Authorization number**:	***Decision Due Date**:
***J-Code**:	**Coverage**: ☐State excludes ☐COB (secondary)
***Line of Business**: ☐Commercial ☐Health Insurance Marketplace ☐Medicaid ☐Medicare	***Benefit**: ☐Medical ☐Pharmacy

***Choose one criteria option below based on line of business**:

Medicare Criteria Only:

☐Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐Centene Policy [**CP.PHAR.593 Delandistrogene Moxeparvovec-rokl (Elevidys)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): ___________

OR

☐State or Health Plan Specific (please include policy)