OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Elevidys (Delandistrogene Moxeparvovec-rokl) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

☐ **Physician billing (HCPCS code:**_____**)** ☐ **Pharmacy billing (NDC:**_____**)**

Dose:_____ ***Regimen:***_____ ***Start Date (or date of next dose):***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Authorization: *(approvals will be for 1 dose per lifetime)*

1. Please indicate the diagnosis and information:
   - ☐ Duchenne muscular dystrophy (DMD)
   - ☐ Other _____
2. Does the member have a confirmed mutation in the DMD gene? Yes☐ No☐
   a. If yes, please submit results of genetic test.
3. Is the member ambulatory? Yes☐ No☐
   a. If yes, please submit the results of one of the following:
      - ☐ North Star Ambulatory Assessment (NSAA)
      - ☐ 6-minute walk test (6MWT)
      - ☐ 10-meter walk test (10mWT)
      - ☐ Ascend 4 Steps
      - ☐ Time to Rise (TTR)
      - ☐ 100-meter timed test
4. Is Elevidys being prescribed by a neurologist or specialist with expertise in the treatment of DMD (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of DMD)? Yes☐ No☐
5. Are the member's baseline anti-AAVrh74 total binding antibody titers <1:400? Yes☐ No☐
6. Does the member have any deletion in exon 8 and/or exon 9 in the DMD gene? Yes☐ No☐
7. Does the member have a deletion in the DMD gene in exon 1-17 and/or exons 59-71? Yes☐ No☐
   a. If yes, will the prescriber monitor the member for severe immune-mediated myositis reaction? Yes☐ No☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

For Authorization *(continued)**:***

8. Does the member have any active infections? Yes☐ No☐
   a. If yes, will Elevidys infusion be postponed until the infection has resolved? Yes☐ No☐
9. Will the member initiate a corticosteroid regimen one day prior to the infusion of Elevidys and continue for a minimum of 60 days to reduce the risk of an immune response as specified in the package labeling? Yes☐ No☐
10. Will liver function tests (LFTs) (e.g., GGT and total bilirubin) be performed prior to Elevidys administration? Yes☐ No☐
11. Will LFTs be monitored weekly for the first 3 months following Elevidys infusion then as clinically indicated? Yes☐ No☐
12. Will troponin-I be monitored before Elevidys infusion and weekly for the first month following infusion then as clinically indicated? Yes☐ No☐
13. Will platelet counts be monitored before Elevidys infusion and weekly for the first 2 weeks then as clinically indicated? Yes☐ No☐
14. Is the member currently receiving exon therapy (e.g. Amondys 45, Exondys 51, Viltepso®, and Vyondys 53)? Yes☐ No☐
    a. If yes, will exon therapy be discontinued before the Elevidys infusion? Yes☐ No☐
15. Member's weight: _____: Date taken: _____
16. Anticipated date of Elevidys infusion: _____
17. Will Elevidys be administered when the member is within the FDA approved age range? Yes☐ No☐

Please note: Member will not be approved for concomitant treatment with exon skipping therapy (e.g. Amondys 45, Exondys 51, Viltepso®, and Vyondys 53) following Elevidys infusion (current authorizations for exon skipping therapy will be discontinued upon Elevidys approval).

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete all pages will result in processing delays.

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