UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Elevidys (delandistrogene moxeparvovec-rokl)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medical Billing Information * indicates required field	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (*All* of the following criteria must be met):

1. Is the patient at least 4 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a confirmed diagnosis of Duchenne muscular dystrophy with a confirmed mutation in dystrophin (DMD) gene? ❑ **Yes** ❑ **No**
3. Is the patient ambulatory? ❑ **Yes** ❑ **No**
4. Is the medication being prescribed by or in consultation with a provider specializing in the treatment of Duchenne muscular dystrophy? ❑ **Yes** ❑ **No**
5. Does the patient NOT have a deletion in the exon 8 and/or exon 9 in the DMD gene? ❑ **Yes** ❑ **No**
6. Has the patient NOT previously received Elevidys treatment? ❑ **Yes** ❑ **No**
7. Does the provider attest that the patient will not receive exon-skipping therapies for DMD concomitantly or following Elevidys treatment? ❑ **Yes** ❑ **No**
8. Does the provider attests to the following:? ❑ **Yes** ❑ **No**
   - ☐ There is no current infection
   - ☐ Liver function has been assessed
   - ☐ Platelet count and troponin-I levels have been obtained

Authorization: One dose per lifetime for 14 days from approval

Note:

- WARNING: ACUTE SERIOUS LIVER INJURY AND ACUTE LIVER FAILURE
  - Acute serious liver injury, including life-threatening and fatal acute liver failure, has occurred with ELEVIDYS.
  - Patients with preexisting liver impairment may be at higher risk.
  - Prior to infusion, assess liver function by clinical examination and laboratory testing. Administer systemic corticosteroids before and after ELEVIDYS infusion. Continue to monitor liver function weekly for the first 3 months after infusion and continue until results are unremarkable.
  - Instruct patients to maintain proximity to an appropriate healthcare facility, as determined by the healthcare provider, for at least 2 months following ELEVIDYS infusion.
  - Obtain prompt consultation with a specialist (e.g., gastroenterologist or hepatologist) if acute serious liver injury or impending acute liver failure is suspected.
- Provider shall review and submit additional Ultra High Cost Drug Forms below at: https://medicaid.utah.gov/pharmacy/resource-library/
  - UHCD Written Claim of Business Confidentiality Form
  - Ultra High Cost Drug Invoice Submission Form

Provider Certification

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date