UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Kebilidi (eladocagene exuparvovec-tneq)

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:
Medically Billed Information * indicates required field for all medically billed products	
*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. Does the patient have a diagnosis of aromatic L-amino acid decarboxylase (AADC) deficiency due to biallelic mutations in the DDC gene, confirmed by molecular genetic testing? ❑ **Yes** ❑ **No**
2. Does the provider attest that the patient has NEVER received Kebilidi before? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**
4. Does the patient have confirmed skull maturity assessed by neuroimaging? ❑ **Yes** ❑ **No**
5. Will Kebilidi be administered by intraputaminal infusion in a medical center that is capable of stereotactic neurosurgery in addition to the preparation and infusion of Kebilidi? ❑ **Yes** ❑ **No**
6. Will Kebilidi be administered using an FDA-authorized cannula for intraparenchymal infusion (e.g., ClearPoint® SmartFlow® Neuro Cannula)? ❑ **Yes** ❑ **No**

Authorization: One dose per lifetime

Note:

- 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