HUSKY Health Program
Elevidys® (delandistrogene moxeparvovec-rokl)
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information			
Member ID #:		Member Name (Last, First):	
DOB:	Sex:	Address:	City, State, Zip:
Diagnosis Code:		HCPCS Code:	Start Date of Service:

Please fill out completely:		
1. Does the individual have a diagnosis of Duchenne Muscular Dystrophy (DMD) with a mutation in the DMD gene, confirmed by genetic testing? ***Please attach genetic testing.***	◯Yes	◯No
2. Does the individual have a deletion of the DMD gene in either of the following locations? ***Please attach genetic testing.***	◯Yes	◯No
a. In exon 8 and/or exon 9?	◯Yes	◯No
b. In exon 1 to 17 and/or exons 59 to 71?	◯Yes	◯No
i. If yes, will the provider monitor the individual for a severe immune-mediated myositis reaction? ***Please attach signed provider attestation.***	◯Yes	◯No
3. Is the individual four to seven years of age?	◯Yes	◯No
4. Is the individual ambulatory? ***Please attach medical record documentation.***	◯Yes	◯No
5. Have at least ONE of the following baseline motor assessments been completed? ***Please check "yes" for all that apply and attach results.***	◯Yes	◯No
a. North Star Ambulatory Assessment (NSAA)	◯Yes	◯No
b. Time to Rise (TTR)	◯Yes	◯No
c. 10-Meter Walk/Run (10MWR) test	◯Yes	◯No
d. Time to ascend four steps	◯Yes	◯No
e. 100-Meter Walk/Run (100MWR) test	◯Yes	◯No
6. Have baseline liver function tests been completed and confirmed that the individual does not have preexisting hepatic impairment, acute liver disease, chronic hepatic disease, or elevated Gamma-Glutamyl Transferase (GGT)? ***Please attach lab work.***	◯Yes	◯No
7. Will liver function continue to be monitored after Elevidys® infusion in accordance with the FDA-approved labeling? ***Please attach signed provider attestation.***	◯Yes	◯No
8. Does the individual have a Left Ventricle Ejection Fraction (LVEF) < 40%? ***Please attach lab work.***	◯Yes	◯No
9. Have baseline troponin-I levels been obtained? ***Please attach lab work.***	◯Yes	◯No
10. Will troponin-I continue to be monitored after Elevidys® infusion in accordance with the FDA-approved labeling? ***Please attach signed provider attestation.***	◯Yes	◯No
11. Have baseline platelet counts been obtained? ***Please attach lab work.***	◯Yes	◯No
12. Will platelet counts continue to be monitored after Elevidys® infusion in accordance with the FDA-approved labeling? ***Please attach signed provider attestation.***	◯Yes	◯No
13. Does the individual have an elevated anti-AAVrh74 total binding antibody titer ≥ 1:400? ***Please attach results of antibody titer.***	◯Yes	◯No
14. Has the individual previously received Elevidys®? ***Please attach signed provider attestation.***	◯Yes	◯No
15. Will Elevidys® be used in combination with exon-skipping therapies (i.e., casimersen, eteplirsen, golodirsen, viltolarsen)? ***Please attach signed provider attestation.***	◯Yes	◯No
16. Does the individual currently have an active infection? ***Please attach signed provider attestation.***	◯Yes	◯No
17. Is the individual up to date on all CDC-recommended childhood vaccines? ***Please attach signed provider attestation.***	◯Yes	◯No
18. Will the individual receive a corticosteroid regimen prior to and following receipt of Elevidys® infusion as per the FDA-approved labeling? ***Please attach signed provider attestation.***	◯Yes	◯No

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19. Is Elevidys® prescribed by, or in consultation with, a physician who specializes in the treatment of DMD? ***If yes, please specify:*** Provider Name: _____ Phone Number: _____	○ Yes	○ No
20. Will the treating provider follow all FDA-approved labeling for dosing, administration, and monitoring for Elevidys®? ***Please attach signed provider attestation.***	○ Yes	○ No

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Provider Signature:	Date: