Reset Form Print Form

Government of District of Columbia Department of Health Care Finance

Prior Authorization Form Elevidys (delandistrogene moxeparvovec-rokl)

Request Date: _____

PATIENT INFORMATION

Patient Medicaid ID: _____

Date of Birth: _____

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____

Prescriber Fax: _____

Prescriber DEA Number: _____

Prescriber NPI Number: _____

Prescriber Specialty: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

Pharmacy NPI Number: _____

Refer to FDA www.fda.gov for prescribing details and approved indications.

PRIOR AUTHORIZATION CRITERIA

Instructions: Ensure the patient meets all the criteria below and check applicable boxes.

☐ The patient is at least 4 but not greater than 20 years of age.

☐ The patient is **ambulatory** and has Duchenne Muscular Dystrophy (DMD) with a confirmed deletion between exons 18 to 58. **Please note the following serious warnings about *DMD* gene deletion:**

- Elevidys is contraindicated in patients with any deletion in exon 8 and/or exon 9.
- Further, patients with certain mutation deletions (in exons 1 to 17 and/or exons 59 to 71) may be at risk for a severe immune-mediated myositis reaction.

☐ The patient's baseline anti-AAvrh74 total binding antibody titer < 1:400.

SUBMIT TO Comagine Health DHCF DC Medicaid:
https://comagine.org/program/dc-medicaid-um

Revision Date: 12/02/2025

Recipient's Name (Last, First): _____

☐ The patient **will NOT** receive DMD-directed antisense oligonucleotides during treatment with Elevidys (e.g., golodirsen, viltolarsen)

☐ If the patient is currently receiving treatment with a DMD-directed antisense oligonucleotides, therapy will be **discontinued** at least 7 days prior to Elevidys

☐ Corticosteroid regimen will initiate one day prior to infusion for a minimum of 60 days. Modify corticosteroid dose for patients with liver function abnormalities.

Regimen and start date: _____

☐ The patient **does NOT** have active infection.

☐ Baseline troponin-I levels assessed and will be monitored before Elevidys infusion, and weekly for the first month after infusion. **Please note: Acute to life-threatening myocarditis and troponin-I elevations have been observed.**

☐ The patient **does NOT** have a left ventricle ejection fraction (LVEF) <40%. **Please note: Patients with pre-existing LVEF impairment may have higher adverse outcomes if myocarditis presents.**

☐ Liver baseline function assessed and weekly after Elevidys dose for the first 3 months. Continue monitoring until results are unremarkable.

Attach copy of baseline liver function tests.

☐ Protocol for Elevidys monitoring attached.

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Submit to Comagine Health DHCF DC Medicaid**:** https://comagine.org/program/dc-medicaid-um.

LENGTH OF AUTHORIZATION CRITERIA AND PRIOR AUTHORIZATION RENEWAL

Single-dose infusion. Not eligible for renewal

DOSAGE AND ADMINISTRATION

Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/

By signature, the prescriber confirms the above information is complete, accurate, and verifiable by member's records.

Prescriber's Signature: _____ **Date:** _____