

New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

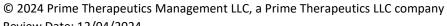
Elevidys (delandistrogene moxeparvovec-rokl)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION R	EQUESTED											
LAST NAME:	FIRST NAME:											
MEDICAID ID NUMBER:	DATE OF BIRTH:											
			-									
GENDER: Male Female												
Drug Name:	th:	:h:										
Dosing Directions:	Length of Therapy:											
SECTION II: PRESCRIBER INFORMATION												
LAST NAME:	FIRST NAME:											
SPECIALTY: NPI NUMBER:												
PHONE NUMBER:	FAX NUMBER:											
		_										
SECTION III: CLINICAL HISTORY												
1. Does the patient have Duchenne Muscular Dystrophy (DMD) with a confirmed deletion between												
exons 18 to 58?												
2. Is the patient's baseline anti-AArh74 total binding antibody titer < 1:400?												
3. Will the patient also receive DMD-directed antisense oligonucleotides during treatment with												
Elevidys (e.g. golodirsen, viltolarsen)?												
4. If the patient is currently receiving treatment with a DMD-directed antisense oligonucleotides, will therapy be discontinued at least 7 days prior to Elevidys?												
5. Will the patient start or continue to use a corticosteroid?												
a. Regimen and start date:					•							
(Form continued on next page.)												

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101



Review Date: 12/04/2024





New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Elevidys (delandistrogene moxeparvovec-rokl)

PATIENT LAST NAME:												PATIENT FIRST NAME:												
SE	CTION	N III: C	LINIC	AL HIS	TORY	,																		
6.	Does	the p	atient	t have	an ac	tive i	nfect	tion?	•														Yes	No
7.		the tro	oponii	n-1 lev	el be	asses	ssed	at ba	selir	ne an	d af	ter E	levid	ys do	se a	ссо	rdin	g to	a fa	cility	,		Yes	☐ No
8.	Will the liver function be assessed at baseline and after Elevidys dose according to a facility protocol?														☐ No									
	a. <i>A</i>	Attach	сору	of bas	eline	liver	func	tion	tests															
9.	Atta	ch pro	tocol	for Ele	vidys	mon	itorir	ng.																
	-		-	additio				n tha	at wo	ould h	nelp	in th	ie de	cisior	n-ma	ıkin	g pr	oces	ss. If	addi	tion	al sp	pace	is
	•			ormati nission	-							-					•		_				stan	d that
PRESCRIBER'S SIGNATURE:												DATE:												
Fa	cility v	where	infusi	ion to	be pr	ovide	d:	_																
Me	edicai	d Prov	/ider N	Numbe	er of F	acilit	y:	_																

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101

