



**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 REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Does the patient have Duchenne Muscular Dystrophy (DMD) with a confirmed deletion between exons 18 to 58? Yes No
- Is the patient's baseline anti-AArh74 total binding antibody titer < 1:400? Yes No
- Will the patient also receive DMD-directed antisense oligonucleotides during treatment with Elevidys (e.g. golodirsen, viltolarsen)? Yes No
- If the patient is currently receiving treatment with a DMD-directed antisense oligonucleotides, will therapy be discontinued at least 7 days prior to Elevidys? Yes No
- Will the patient start or continue to use a corticosteroid? Yes No

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

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Elevidys (delandistrogene moxeparvovec-rokl)

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY

- 6. Does the patient have an active infection? Yes No
- 7. Will the troponin-1 level be assessed at baseline and after Elevidys dose according to a facility protocol? Yes No
- 8. Will the liver function be assessed at baseline and after Elevidys dose according to a facility protocol? Yes No
 - a. Attach copy of baseline liver function tests.
- 9. Attach protocol for Elevidys monitoring.

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

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____