Reset Form Print Form

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

Kebilidi™ (eladocagene exuparvovec-tneq)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

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 severe aromatic L-amino acid decarboxylase (AADC) deficiency? ☐ Yes ☐ No
   a. Was the diagnosis confirmed with genetic testing demonstrating biallelic pathogenic variants in DOPA decarboxylase gene? ☐ Yes ☐ No
   b. Was the cerebrospinal fluid or plasma neurotransmitter profile consistent with AADC deficiency? ☐ Yes ☐ No
   c. Does the patient have reduced plasma AADC enzyme activity? ☐ Yes ☐ No
2. Is the patient experiencing persistent neurological defects secondary to AADC deficiency? ☐ Yes ☐ No
   Describe: _____
3. Has the patient been maintained on stable doses for at least 3 months of standard medical therapy for AADC? ☐ Yes ☐ No
   Describe: _____
4. Is the patient able to ambulate independently? ☐ Yes ☐ No

Fax to DHHS; medication is administered in inpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-314-8101

Review Date: 06/05/2025

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PATIENT LAST NAME:

PATIENT FIRST NAME:

5. Has the patient achieved skull maturity as assessed by neuroimaging? ☐ Yes ☐ No
6. Does the patient have pyridoxine 5'-phosphate oxidase or tetrahydrobiopterin deficiency? ☐ Yes ☐ No
7. Has the patient received any prior gene therapy? ☐ Yes ☐ No
8. Has the patient been determined to be negative for baseline anti-adeno-associated virus serotype 2 antibodies? ☐ Yes ☐ No
9. Does the patient have any contraindications for surgical intra-putaminal administration? ☐ Yes ☐ No
10. Is the patient a female of reproductive potential? ☐ Yes ☐ No

    If yes, a pregnancy test will be performed prior to administration of Kebilidi™.

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 is to be provided: _____

Medicaid Provider Number of Facility: _____

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