Elevidys (delandistrogene moxeparvovec-rokl)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(at least one of the following criteria must be met)*

- ❑ Medication is prescribed by a physician who specializes in the treatment of Duchenne muscular dystrophy
- ❑ The patient has a confirmed diagnosis of Duchenne muscular dystrophy.
- ❑ The patient is ambulatory **AND** aged 4 through 5 years.
- ❑ The patient has a confirmed mutation in dystrophin (DMD) gene consistent with Duchenne muscular dystrophy. Chart Note Page #: _________
- ❑ The patient does not have a deletion in exon 8 and/or exon 9 in the DMD gene
- ❑ The member has not previously received Elevidys treatment
- ❑ The member will not receive exon-skipping therapies for DMD concomitantly or following Elevidys treatment
- ❑ The provider attests to the following:
  - There is no current infection
  - Liver function has been assessed
  - Platelet count and troponin-I levels have been obtained

Authorization: One dose per lifetime for 14 days from approval or until the patient reaches 6 years of age, whichever is sooner

Note:

- Use appropriate HCPCS codes for billing
- Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
- HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_______________________________________ _______________

Prescriber's Signature Date