MASSACHUSETTS

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Gene Therapies for Duchenne Muscular Dystrophy
Prior Authorization Request Form for Elevidys™ (delandistrogene moxeparvovec-rokl), #025

Medical Policy #022 Gene Therapies for Duchenne Muscular Dystrophy

CLINICAL DOCUMENTATION

- Clinical documentation that supports the medical necessity criteria for Elevidys™ (delandistrogene moxeparvovec-rokl) must be submitted.
- If the patient does not meet all the criteria listed below, please submit a letter of medical necessity with a request for Clinical Exception (Individual Consideration) explaining why an exception is justified.

Requesting Prior Authorization Using Authorization Manager

Providers will need to use Authorization Manager to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

- Refer to our Authorization Manager page for tips, guides, and video demonstrations.

Complete Prior Authorization Request Form for Elevidys (delandistrogene moxparvovec-rokl) (025) using Authorization Manager.

For out of network providers: Requests should still be faxed to 888-973-0726.

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Place of Service: Outpatient ❒ Inpatient ❒ Distributor:

Physician Information	**Facility Information**
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

Please check off if the patient has the following diagnosis:	
Duchenne muscular dystrophy (DMD)	❒

Please check off that the patient meets ALL the following criteria:	
1. Diagnosis of DMD by or in consultation with a pediatric neuromuscular specialist in DMD with: a. A confirmed mutation in the DMD gene; **AND** b. Mutation is not a deletion in exon 8 and/or 9; **AND**	❒
2. Elevidys is prescribed by or in consultation with a pediatric neuromuscular specialist in DMD; **AND**	❒
3. Patient is 4 - 5 years old; **AND**	
4. Patient is ambulatory without need of assistive devices (e.g., cane, walker, wheelchair, side-by-side assistance, etc.) as determined by medical records or physician attestation; **AND**	❒
5. Patient does not have an anti-AAVrh74 total binding antibody titer ≥ 1:400; **AND**	❒
6. Patient is on a corticosteroid regimen: a. Stable corticosteroid regimen defined as ≥ 12 weeks prior to screening for Elevidys infusion and following infusion; **OR** b. Corticosteroid is not medically/clinically appropriate as per managing provider's recommendations; **AND**	❒
7. Patient has not previously received a gene therapy with Elevidys in their lifetime; **AND**	❒
8. Prescriber attestation patient will not receive any exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following treatment with Elevidys; **AND**	❒
9. Prescriber will assess liver function, platelets, and troponin-I levels prior to Elevidys infusion.	❒

HCPCS Codes	Code Description
J3590	Unclassified biologics
J3490	Unclassified drugs
C9399	Unclassified drugs or biologicals

Providers should enter the relevant diagnosis code(s) below:

Code	Description	
		❒
		❒

Providers should enter other relevant code(s) below:

Code	Description	
		❒
		❒