ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Delandistrogene Moxeparvovec-rokl (Elevidys)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Duchenne muscular dystrophy (DMD) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Elevidys (Delandistrogene Moxeparvovec-rokl)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with a neurologist? ☐Yes ☐No
2. Is patient being treated at a certified Duchenne care center or an MDA care center?
   ☐Yes, please provide care center name: _____ ☐No
3. Please provide patient's weight documented within the last 90 days: _____ kg; date: _____
4. Is DMD confirmed by genetic testing? ☐Yes ☐No
5. Does patient have deletion in exon 8 and/or 9 in the DMD gene? ☐Yes ☐No
6. Does patient have ambulatory function (e.g., able to walk without assistive devices, not wheelchair dependent)? ☐Yes ☐No
7. Does patient have an active infection? ☐Yes ☐No
8. Has patient had all of the following assessed within the last 30 days? ☐Yes **Mark all that apply** ☐No
   ☐Baseline platelet count ☐Baseline troponin I ☐Stable cardiac function with left ventricular ejection fraction (LVEF) ≥ 40%
   ☐Baseline liver function tests (e.g., AST, ALT, bilirubin) with absence of significant liver dysfunction (defined as acute liver disease, pre-existing liver dysfunction, chronic hepatic condition)
9. Is there documentation of baseline laboratory test demonstrating anti-AAVrh74 total binding antibody titers < 1:400 as determined by ELISA binding immunoassay? ☐Yes ☐No
10. Does provider attest patient will be initiated on standard of care oral corticosteroid prior to and following Elevidys? ☐Yes ☐No
11. Has patient been on a stable dose of an oral corticosteroid for ≥ 3 months? ☐Yes **Mark all that apply** ☐No
    ☐Prednisone ☐Yes ☐No ☐Contraindicated/intolerant
    ☐Emflaza ☐Yes ☐No ☐Contraindicated/intolerant
    ☐Agamree ☐Yes ☐No ☐Contraindicated/intolerant
    ☐Other: _____ ☐Yes ☐No ☐Contraindicated/intolerant
12. Has patient been previously treated with Elevidys? ☐Yes ☐No
13. Has patient been previously treated with investigational agent deramiocel (CAP-1002)? ☐Yes ☐No
14. Is patient currently on exon skipping therapy?
    ☐Yes* **Mark all that apply** ☐No
    ☐Amondys 45 ☐Exondys 51 ☐Viltepso ☐Vyondys 53 ☐Other: _____
    a. *If yes*, will patient discontinue exon skipping therapy prior to Elevidys and not-reinitiate exon skipping therapy after Elevidys?
       ☐Yes ☐No
15. Is Elevidys prescribed concurrently with any of the following? **Mark all that apply**

PDAC updated: 09/08/2025
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☐ Amondys 45	☐ Yes	☐ No	☐ Contraindicated/intolerant
☐ Exondys 51	☐ Yes	☐ No	☐ Contraindicated/intolerant
☐ Viltepso	☐ Yes	☐ No	☐ Contraindicated/intolerant
☐ Vyondys 53	☐ Yes	☐ No	☐ Contraindicated/intolerant
☐ Prophylactic oral corticosteroid	☐ Yes: _____	☐ No	☐ Contraindicated/intolerant
☐ Other	☐ Yes: _____	☐ No	☐ Contraindicated/intolerant

Please continue to page 2.

Patient Name: _____ **DOB:** _____

16. How many Elevidys infusion(s) has patient received in their lifetime? ☐ 0 ☐ ≥ 1

Complete this section ONLY for indications other than DMD:

17. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No

If yes, submit documentation and answer the following:

a. Please list all previous therapies: _____

b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Information

***Number:**	***Date of Request:**
***HCPCS Code:**	***Decision Due Date:**
* **Line of Business:** ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* **Benefit:** ☐ Medical ☐ Pharmacy

*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.593 Delandistrogene Moxeparvovec-rokl (Elevidys)**]

Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)