ambetter. FROM peach state health plan

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

Eladocagene Exuparvovec-tneq (Kebilidi)
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:

☐ Aromatic L-amino acid decarboxylase (AADC) deficiency ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Kebilidi (Eladocagene Exuparvovec-tneq)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Is Kebilidi prescribed by or in consultation with a geneticist or neurologist? ☐ Yes ☐ No
2. Is AADC deficiency evidenced by documentation of positive testing from 2 of the following core diagnostic tests?
   ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Cerebrospinal fluid (CSF) neurotransmitter metabolite panel ☐ Single gene or genetic panel testing
   ☐ Plasma enzyme assay ☐ Other: _____
3. Is there evidence of classic clinical symptoms of AADC deficiency? ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Movement disorders (hypotonia, dystonia, dyskinesia, tremor, myoclonus, oculogyric crisis, hypokinesia): _____
   ☐ Developmental delay (motor development, cognitive development, speech development): _____
   ☐ Tone regulation (floppy infant, hypotonia, hypertonia, poor head control): _____
   ☐ Other: _____
4. Is there documentation patient has achieved skull maturity by neuroimaging? ☐ Yes ☐ No
5. Is there documentation of baseline laboratory tests demonstrating anti-AAV2 neutralizing antibody titer does not exceed > 1,200 fold or ELISA optical density (OD) > 1? ☐ Yes: _____ fold or _____ OD ☐ No
6. Has patient previously received a dose of Kebilidi? ☐ Yes ☐ No

Complete this section ONLY for indications <u>other</u> than AADC deficiency:

7. 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:

PDAC updated: 09/08/2025
AMB25-GA-HP-00216

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PDAC Drug Review Form

* **Line of Business:**	* **Benefit:**
☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	☐ Medical ☐ Pharmacy

Please continue to page 2.

Patient Name: _____ **DOB:** _____

* **Line of Business:**	* **Benefit:**
☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	☐ 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.595 Eladocagene Exuparvovec-tneq (Kebilidi)**]
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)