

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

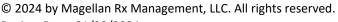
Elevidys (delandistrogene moxeparvovec-rokl)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION R	REQUESTED											
LAST NAME:	FIRST NAME:											
MEDICAID ID NUMBER:	DATE OF BIRTH:											
GENDER: Male Female												
Drug Name:	Strength:	Strength:										
Dosing Directions:	Length of Therapy:	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 Duchenne Muscular Dystrophy (DMD) without a confirmed deletion in												
exons 8 and/or 9?												
2. Is the patient's baseline anti-AArh74 total binding ant	Yes No											
3. Is the patient ambulatory?												
North Star Ambulatory Assessment score: ————		_										
4. Will the patient also receive DMD-directed antisense	oligonucleotides during treatment with	Yes No										
Elevidys (e.g. golodirsen, viltolarsen)?												
5. If the patient is currently receiving treatment with a DMD-directed antisense oligonucleotides,												
will therapy be discontinued at least 7 days prior to El	levidys?											
6. Will the patient start or continue to use a corticosteroid?												
a. Regimen and start date: ————————————————————————————————————		_										
(Form continued on next page.)												

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101



Review Date: 01/29/2024





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PATIENT LAST NAME:												PATIENT FIRST NAME:														
SE	CTIO	V III:	CLINI	CAL	. HIS	ΓORY	7																			
7.	Does	s the	patie	nt h	nave	an ac	tive i	infect	tion?)														Yes	s	No
8.		Vill the troponin-1 level be assessed at baseline and after Elevidys dose according to a facility Yes No protocol?																								
9.		the li ocol?		unct	tion l	oe as	sesse	ed at l	basel	line a	and a	fter	r Elev	vidys (dose	acco	ord	ing	to a	faci	lity] Yes	s [_ No
	a. <i>I</i>	Attac	h cop	y of	f bas	eline	liver	func	tion t	tests																
10.	Atta	ch pr	otoco	ol fo	r Ele	vidys	mon	nitorir	ng.																	
	ease p			_					n tha	it wo	uld h	nelp	in th	ne dec	cisior	า-ma	akir	ng p	roce	ess. I	f add	litio	nal s	расє	e is	
	-					-							•	e to t				•						rstaı	nd 1	that
PR	ESCR	IBER'	S SIG	NA ⁻	TURE	<u></u>														D	ATE:					
Fac	cility	wher	e infu	ısioı	n to l	oe pr	ovide	ed:	_																	
Me	edicai	id Pro	vide	r Nu	ımbe	r of I	acilit	y:																		

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