Reset Form Print Form

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 REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

SECTION III: CLINICAL HISTORY

1. Is the patient ≥ 4 years of age? ☐ Yes ☐ No
2. Does the patient have Duchenne Muscular Dystrophy (DMD) with a confirmed deletion between exons 18 to 58? ☐ Yes ☐ No
3. Is the patient's baseline anti-AArh74 total binding antibody titer < 1:400? ☐ Yes ☐ No
4. Is the patient ambulatory confirmed by a North Star Ambulatory Assessment scale score ≥ 1? ☐ Yes ☐ No
5. Will the patient also receive DMD-directed antisense oligonucleotides during treatment with Elevidys (e.g. golodirsen, viltolarsen)? ☐ Yes ☐ No
6. If the patient is currently receiving treatment with a DMD-directed antisense oligonucleotides, will therapy be discontinued at least 7 days prior to Elevidys? ☐ Yes ☐ No
7. Will the patient start or continue to use a corticosteroid? ☐ Yes ☐ No
   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: 06/02/2026

Prime THERAPEUTICS™

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY

8. Does the patient have an active infection? ☐ Yes ☐ No
9. Will the troponin-1 level be assessed at baseline and after Elevidys dose according to a facility protocol? ☐ Yes ☐ No
10. Will the liver function be assessed at baseline and after Elevidys dose according to a facility protocol? ☐ Yes ☐ No
    a. Attach copy of baseline liver function tests.
11. Attach protocol for Elevidys monitoring.

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____

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