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## ELEVIDYS PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
First Date of Service:	Last Date of Service:	
Primary Diagnosis Code:	HCPC Code:	
Drug Name:	Dose & Frequency:	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
<b>POINT OF CONTACT</b>		
Name and Title:		
Email:	Phone:	Fax:
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:	Taxonomy:	
Phone:	Fax:	

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Therapy is prescribed by with a neurologist who specializes in the treatment of DMD and/or other neuromuscular disorders	
	Individual has a diagnosis of DMD confirmed by genetic testing	
	Individual does not have any deletion in exon 8 and/or exon 9 DMD gene	
	Individual is ambulatory (e.g. is not dependent on assistive devices and is not wheelchair dependent) and has a North Star Ambulatory Assessment (NSAA) score documented at baseline	
	Individual is 4-7 years of age	
	Individual meets one of the following regarding DMD antisense oligonucleotides <ul style="list-style-type: none"> <li>• Individual is not currently taking any DMD antisense oligonucleotides</li> <li>• DMD antisense oligonucleotide therapy will be discontinued prior to Elevidys infusion</li> </ul>	
	Baseline labs are completed and anti-AAVrh74is not $\geq 1:400$	
	Individual has not received Elevidys therapy in the past	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
This form <u>must be</u> signed by a neurologist		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		