Elevidys™ (delandistrogene moxeparvovec-rokl) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Neurologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Elevidys (delandistrogene moxeparvovec-rokl) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

☐ Yes ☐ No Does the patient have a diagnosis of Duchenne muscular dystrophy (DMD)?
☐ Yes ☐ No Will the requested medication be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD)?
☐ Yes ☐ No Does the patient have a definitive diagnosis of Duchenne muscular dystrophy (DMD) confirmed via genetic testing?
→ Please enter the date genetic testing was completed: Date: ____/____/____
☐ Yes ☐ No Does the patient have a deletion in the exon 8 and/or exon 9 in the DMD gene?
☐ Yes ☐ No Will the requested medication be used in combination with exon-skipping therapies (e.g., casimersen, eteplirsen, golodirsen, viltolarsen)?
☐ Yes ☐ No Is the patient ambulatory (e.g., able to walk with or without assistance, not wheelchair dependent)?
☐ Yes ☐ No Is patient's anti-adeno-associated virus rh74 (AAVrh74) total binding antibody titers less than 1:400?
☐ Yes ☐ No Has the patient previously received the requested medication?
☐ Yes ☐ No Will the administration of Elevidys (delandistrogene moxeparvovec-rokl) be provided at an Aetna gene therapy designated center?

Please provide the name of the gene therapy designated center where the administration will be provided: Name: _____

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.