

**Clinical Criteria Worksheet:
(Elevidys®) delandistrogene moxeparvovec-rokl**

Enrollee Information

Enrollee Last Name:

Enrollee First Name:

Date of Birth (MM/DD/YYYY):

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

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Address:

City, Town or Post Office:

State:

ZIP Code:

Prescriber Information

Prescriber Last Name:

Prescriber First Name:

National Provider Identifier (NPI) Number: _____

Preferred Contact (Telephone Number): _____

Drug Information

Drug Administration:

Provide the date of expected/ or drug administration (MM/DD/YYYY):

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Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

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Enrollee Last Name:

Enrollee First Name:

Clinical Criteria

1. Is the patient four (4) or five(5) years of age?

Yes

No

2. Is the patient male?

Yes

No

3. Does the patient have a diagnosis of Duchenne Muscular Dystrophy(DMD) confirmed by genetic testing?

Yes

No

a. Does the patient have a deletion in exon 8 and/or 9 in the DMD gene?

Yes

No

4. Prescriber must attest that the patient is ambulatory using standard function assesments. (must be documented in the patient's medical record)

Yes

No

5. Prescriber must attest that **administration will not occur unless all current Food and Drug Administration (FDA) product safety requirements have been met.**

Current FDA product safety requirements are located here: <https://www.fda.gov/drugs/laws-acts-and-rules/fdas-labeling-resources-human-prescription-drugs>

Yes

No

Enrollee Last Name:

Enrollee First Name:

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

Prescriber Signature (Required)

Date (MM/DD/YYYY)