Pharmacy Drug Policy Checklist

POLICY NAME	Elevidys (delandistrogene moxeparvovec)	POLICY #	2778P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of Duchenne muscular dystrophy as confirmed by genetic testing documenting a mutation in the dystrophin (DMD) gene
- ☐ **1.2** Documentation of muscle biopsy documenting lack of muscle dystrophin
- ☐ **1.3** Prescribed by or in consultation with a doctor who specializes in the treatment of Duchenne Muscular Dystrophy (DMD)
- ☐ **1.4** Documentation supports patient is currently able to walk independently and not wheelchair dependent
- ☐ **1.5** Patient is age 4-7 years
- ☐ **1.6** Documentation of a baseline motor milestone score from North Star Ambulatory Assessment (NSAA)
- ☐ **1.7** Patient will receive a corticosteroid regimen prior to and following receipt of Elevidys
- ☐ **1.8** Review of clinical information confirming that patient has met all of the above requirements for treatment completed by both a pharmacist and medical director

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Patient is non-ambulatory (unable to walk independently)
  - Use in these patients is still pending further clinical benefit confirmation
- ☐ **2.2** Patient has previously received treatment with an exon-skipping DMD therapy or Elevidys
- ☐ **2.3** Member has a deletion in exon 8 and/or exon 9 in the DMD gene