

## Medical Policy:

### Elevidys® (delandistrogene moxeparvovec-rokl) Intravenous – MEDICAID ONLY

POLICY NUMBER	LAST REVIEW	ORIGIN DATE
MG.MM.PH.420	September 12, 2024	September 12, 2024

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

## Definitions

Elevidys is indicated for the treatment of Duchenne muscular dystrophy (DMD) in individuals at least 4 years of age:

- For patients who are ambulatory and have a confirmed mutation in the DMD gene
- For patients who are non-ambulatory and have a confirmed mutation in the DMD gene.

The DMD indication in non-ambulatory patients is approved under accelerated approval based on expression of ELEVIDYS micro-dystrophin (noted hereafter as “micro-dystrophin”) in skeletal muscle. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

## Length of Authorization

Coverage will be provided for one dose (for Medicaid members) and may not be renewed.

## Dosing Limits [Medical Benefit]

### Max Units (per dose and over time) [HCPCS Unit]:

- 1 therapeutic dose (up to 70 vials [700 mL] based on weight chart in package insert)

## Guideline

### 1. Duchenne Muscular Dystrophy (DMD) †

- A. Patient is at least 4 years of age; **AND**
- B. Patient is not on concomitant therapy with DMD-directed antisense oligonucleotides (e.g., golodirsen, casimersen, viltolarsen, eteplirsen, etc.); **AND**
- C. Patient has not received a DMD-directed antisense oligonucleotide within the past 30 days; **AND**
- D. Patient does not have an active infection, including clinically important localized infections; **AND**
- E. Patient has been on a stable dose of a corticosteroid, unless contraindicated or intolerance, prior to start of therapy and will be used concomitantly with a corticosteroid regimen pre and post- infusion (refer to the package insert for recommended corticosteroid dosing during therapy); **AND**
- F. Patient troponin-I levels will be monitored at baseline and subsequently as clinically indicated; **AND**
- G. Patient will have baseline liver function assessed prior to and following therapy for at least 3 months and as indicated; **AND**
- H. Patient has a confirmed mutation of the *DMD* gene between exons 18-58; **AND**
- I. Patient is receiving physical and/or occupational therapy; **AND**
- J. Patient must have a baseline anti-AAVrh74 total binding antibody titer of < 1:400 as measured by ELISA (*Note: An FDA authorized test for the detection of AAVrh74 total binding antibodies is not currently available. Currently available tests may vary in accuracy and design.*); **AND**
- K. Patient does NOT have any deletion in exon 8 and/or exon 9 in the DMD gene

† FDA Approved Indication(s)

## Applicable Procedure Codes

Code	Description
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose

## Applicable NDCs

Code	Description
60923-0501-10	Elevidys 10.0-10.4 Kg
60923-0502-11	Elevidys 10.5-11.4 kg
60923-0503-12	Elevidys 11.5-12.4 kg
60923-0504-13	Elevidys 12.5-13.4 kg
60923-0505-14	Elevidys 13.5-14.4 kg
60923-0506-15	Elevidys 14.5-15.4 kg
60923-0507-16	Elevidys 15.5-16.4 kg
60923-0508-17	Elevidys 16.5-17.4 kg
60923-0509-18	Elevidys 17.5-18.4 kg
60923-0510-19	Elevidys 18.5-19.4 kg
60923-0511-20	Elevidys 19.5-20.4 kg
60923-0512-21	Elevidys 20.5-21.4 kg
60923-0513-22	Elevidys 21.5-22.4 kg
60923-0514-23	Elevidys 22.5-23.4 kg
60923-0515-24	Elevidys 23.5-24.4 kg
60923-0516-25	Elevidys 24.5-25.4 kg
60923-0517-26	Elevidys 25.5-26.4 kg

60923-0518-27	Elevidys 26.5-27.4 kg
60923-0519-28	Elevidys 27.5-28.4 kg
60923-0520-29	Elevidys 28.5-29.4 kg
60923-0521-30	Elevidys 29.5-30.4 kg
60923-0522-31	Elevidys 30.5-31.4 kg
60923-0523-32	Elevidys 31.5-32.4 kg
60923-0524-33	Elevidys 32.5-33.4 kg
60923-0525-34	Elevidys 33.5-34.4 kg
60923-0526-35	Elevidys 34.5-35.4 kg
60923-0527-36	Elevidys 35.5-36.4 kg
60923-0528-37	Elevidys 36.5-37.4 kg
60923-0529-38	Elevidys 37.5-38.4 kg
60923-0530-39	Elevidys 38.5-39.4 kg
60923-0531-40	Elevidys 39.5-40.4 kg
60923-0532-41	Elevidys 40.5-41.4 kg
60923-0533-42	Elevidys 41.5-42.4 kg
60923-0534-43	Elevidys 42.5-43.4 kg
60923-0535-44	Elevidys 43.5-44.4 kg
60923-0536-45	Elevidys 44.5-45.4 kg
60923-0537-46	Elevidys 45.5-46.4 kg
60923-0538-47	Elevidys 46.5-47.4 kg
60923-0539-48	Elevidys 47.5-48.4 kg
60923-0540-49	Elevidys 48.5-49.4 kg
60923-0541-50	Elevidys 49.5-50.4 kg
60923-0542-51	Elevidys 50.5-51.4 kg
60923-0543-52	Elevidys 51.5-52.4 kg
60923-0544-53	Elevidys 52.5-53.4 kg
60923-0545-54	Elevidys 53.5-54.4 kg
60923-0546-55	Elevidys 54.5-55.4 kg
60923-0547-56	Elevidys 55.5-56.4 kg
60923-0548-57	Elevidys 56.5-57.4 kg
60923-0549-58	Elevidys 57.5-58.4 kg
60923-0550-59	Elevidys 58.5-59.4 kg
60923-0551-60	Elevidys 59.5-60.4 kg
60923-0552-61	Elevidys 60.5-61.4 kg
60923-0553-62	Elevidys 61.5-62.4 kg
60923-0554-63	Elevidys 62.5-63.4 kg
60923-0555-64	Elevidys 63.5-64.4 kg
60923-0556-65	Elevidys 64.5-65.4 kg
60923-0557-66	Elevidys 65.5-66.4 kg
60923-0558-67	Elevidys 66.5-67.4 kg
60923-0559-68	Elevidys 67.5-68.4 kg
60923-0560-69	Elevidys 68.5-69.4 kg
60923-0561-70	Elevidys 69.5 kg plus

## ICD-10 Diagnoses

Code	Description
G71.01	Duchenne or Becker muscular dystrophy

## Revision History

Company(ies)	DATE	REVISION
EmblemHealth & ConnectiCare	9/12/2024	New Policy

## References

1. Elevidys® intravenous infusion [prescribing information]. Cambridge, MA: Sarepta Therapeutics, Inc.; June 2024.