Eladocagene Exuparvovec (Upstaza)

peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Prior Authorization Form/Prescription

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____/____/_____
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #:	Group #:	ID #:	Group #:

Physician Information

*Name:	*Specialty:	NPI:
*Phone #:	Secure Fax #:	Office Contact:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Aromatic L-amino acid decarboxylase (AADC) deficiency ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Upstaza (Eladocagene Exuparvovec)				

Clinical Information ***** *Please submit supporting clinical documentation* *****

***THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY

Therapy start date: _____

If prescribed dose exceeds the FDA maximum recommended dose, please submit supporting practice guidelines/peer-reviewed literature

1. Is therapy prescribed by or in consultation with a geneticist or neurologist? ☐Yes ☐No
2. Is ADDC deficiency evidenced by documentation of positive testing from 2 of the following core diagnostic tests?
   ☐Yes ***Mark all that apply*** ☐No
   ☐Cerebrospinal fluid (CSF) neurotransmitter metabolite panel ☐Single gene or genetic panel testing
   ☐Plasma enzyme assay ☐Other: _____
3. Is there evidence of classic clinical symptoms of AADC deficiency? ☐Yes ***Mark all that apply*** ☐No
   ☐Movement disorders (hypotonia, dystonia, dyskinesia, tremor, myoclonus, oculogyric crisis, hypokinesia): _____
   ☐Developmental delay (motor development, cognitive development, speech development): _____
   ☐Tone regulation (floppy infant, hypotonia, hypertonia, poor head control): _____
   ☐Other: _____
4. Is there documentation of baseline laboratory tests demonstrating anti-AAV2 neutralizing antibody titer does not exceed > 1,200 fold or ELISA optical density (OD) > 1? ☐Yes: _____ fold or _____ OD ☐No
5. Has disease progressed following use of at least 2 of the following symptomatic relief therapies?
   ☐Yes ***Mark all that apply*** ☐No ☐Contraindicated/intolerant
   ☐Dopamine agonists (e.g., pramipexole, ropinirole, rotigotine): _____
   ☐Monoamine oxidase (MAO) inhibitors (e.g., selegiline, tranylcypromine): _____
   ☐Pyridoxine ☐Other: _____
6. **If patient ≤ 2**, does provider attest that head circumference is big enough for surgery? ☐Yes ☐No

Complete this section ONLY for indications <u>other</u> than AADC deficiency:

7. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

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Please continue to page 2.

Patient Name: _____ **DOB:** _____

Physician's Signature _____ **Date:** _____ ☐ **DAW**

INFORMATION BELOW IS TO BE COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

Authorization Information

***Authorization number:**	***Decision Due Date:**
***J-Code:**	**Coverage:** ☐State excludes ☐COB (secondary)
***Line of Business:** ☐Commercial ☐Health Insurance Marketplace ☐Medicaid ☐Medicare	***Benefit:** ☐Medical ☐Pharmacy

***Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐Medicare National Coverage Decision (NCD). _____
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

_____

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐Centene Policy [**CP.PHAR.595 Eladocagene Exuparvovec (Upstaza)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

OR

☐State or Health Plan Specific (please include policy) _____