

delandistrogene moxeparvovec (Elevidys)

HCPCS: J1413 Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys)

LOB:	MCAL
Duration of Approval:	One treatment per lifetime
Quantity Limit:	Per FDA Approved/Compendia Supported Dosing
MCG Available:	Yes
DHCS Drug Policy:	No

Requires Prior Authorization

Elevidys (delandistrogene moxeparvovec) injection

****All requests must be approved by a Medical Director******PA CRITERIA FOR APPROVAL:**

1. The member has a diagnosis for an FDA approved indication (*refer to package insert under References*) OR a compendia supported (Drugdex or AHFS) indication **AND**
2. The medication is prescribed by a neurologist or pediatric neuromuscular specialist **AND**
3. Genetic test result is provided showing ALL of the following (**a-b**):
 - a. Mutation in the DMD gene
 - b. The mutation is NOT a deletion in exon 8 or exon 9**AND**
4. Chart notes or clinical motor assessment (e.g., North Star Ambulatory Assessment [NSAA], time to rise [TTR] from the floor, 10-meter walk/run test [10MWR]) provided confirming the member is ambulatory without needing an assistive device **AND**
5. The member has lab result showing anti-AAVrh74 total binding antibody titer < 1:400 **AND**
6. The member does NOT have any of the following:
 - a. Preexisting liver impairment (defined as GGT > 2x ULN or total bilirubin > ULN not due to Gilbert's syndrome) or active hepatic viral infection
 - b. Recent vaccination (within 4 weeks of treatment)
 - c. Active or recent (within 4 weeks) infections
 - d. Left ventricle ejection fraction (LVEF) < 40%**AND**
7. The member will not be taking Elevidys concurrently with an exon-skipping treatment for DMD (e.g., Amondys 45, Exondys 51, Viltepso, Vyondys 53) **AND**
8. The member has not previously received Elevidys [**Note:** only 1 treatment of Elevidys per life-time is allowed]

OTHER INFORMATION:

HCPCS	Description	Brand name
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Elevidys
**Refer to DHCS Physician-Administered Drugs (PADs) Special Billing for (Elevidys) for billing information and follow allowable number of units to approve. **		

REFERENCES:

1. Elevidys Prescribing Information. <https://www.elevidys.com/pi>. 11/2025.
2. DHCS Cell and Gene Therapy Overview. mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/821726E2-2EAB-4A86-AA42-4778E89A38FD/celgenover.pdf?access_token=6UyVkRRfByXTZEWlh8j8QaYyIPyP5ULO. 09/2025.

UMC REVIEW:

6/2026

delandistrogene moxeparvovec (Elevidys)

HCPCS: J1413 Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys)
