OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Kebilidi™ (eladocagene exuparvovec-tneq) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Physician billing (HCPCS code: _____***)*** ***Start Date:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Authorization: (Only one Kebilidi™ treatment will be approved per member per lifetime):

1. Please indicate member's diagnosis:
   - ☐ Aromatic L-amino acid decarboxylase (AADC) deficiency
   - ☐ Other: _____
2. Was diagnosis confirmed by the following:
   a. Genetic testing confirming biallelic pathogenic or likely pathogenic mutations in the *DDC* gene (*results of genetic testing must be submitted*) Yes☐ No☐
   b. Functional confirmation with measured diagnostic variations in AADC enzyme activity in plasma and/or levels of neurotransmitter metabolites in cerebrospinal fluid (CSF) (*results of testing must be submitted*) Yes☐ No☐
3. For females of reproductive potential:
   a. Is the member pregnant? Yes☐ No☐
   b. Will the member have a negative pregnancy test prior to Kebilidi™ administration? Yes☐ No☐
4. Is Kebilidi™ prescribed by a neurologist, neurosurgeon, or a specialist with expertise in the treatment of AADC deficiency? Yes☐ No☐
5. Does the member have confirmed skull maturity as assessed by neuroimaging? Yes☐ No☐
6. Will Kebilidi™ be administered by intraputaminal infusion in a medical centr that specializes in stereotactic neurosurgery in addition to the preparation and infusion of Kebilidi™? Yes☐ No☐
7. Will Kebilidi™ be shipped via cold chain supply to the facility where the member is scheduled to receive treatment? Yes☐ No☐ Name of facility: _____
   a. Is the facility capable of adhering to the storage, handling, and preparation requirements as described in the package labeling? Yes☐ No☐
8. Will Kebilidi™ be administered using an FDA-authorized cannula for intraparenchymal infusion (e.g., ClearPoint® SmartFlow® Neuro Cannula)? Yes☐ No☐

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Failure to complete this form in full and attach requested clinical notes will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.