

delandistrogene moxeparvovec-rokl (Elevidys[®])

Policy # 00859

Original Effective Date: 03/11/2024

Current Effective Date: 04/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider the use of delandistrogene moxeparvovec-rokl (Elevidys[®])[†] for the treatment of Duchenne Muscular Dystrophy to be **eligible for coverage**** when the patient selection criteria are met.

Patient Selection Criteria

Coverage eligibility for delandistrogene moxeparvovec-rokl (Elevidys) will be considered when the following criteria are met:

- Patient has a diagnosis of Duchenne Muscular Dystrophy and has confirmed ALL of the following:
 - A pathogenic variant in the *DMD* gene between exons 18-58; AND
(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)
 - No deletion in exon 8 or exon 9 in the *DMD* gene; AND
- Patient is greater than or equal to 4 years of age and less than or equal to 5 years of age; AND
(Note: the upper age limit is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)
- Patient does not have a history of receiving Elevidys or any prior gene therapy and is not under consideration for treatment with another gene therapy for DMD; AND
(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)
- Patient is ambulatory without needing an assistive device (e.g., side-by-side assist, wheelchair, cane, walker, etc); AND
- Elevidys will NOT be used in combination with exon-skipping therapies for DMD (e.g., casimersen [Amondys[™]][‡], eteplirsen [Exondys 51[™]][‡], viltolarsen [Viltepso[™]][‡], golodirsen [Vyondys 53[™]][‡]); AND

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- Elevidys WILL be used in combination with recommended doses of corticosteroids (maintenance steroids unless intolerant and high dose steroids surrounding treatment as recommended by FDA-approved prescribing information); AND
- Anti-adeno-associated virus serotype rh74 (AAVrh74) total binding antibody titers are less than 1:400; AND
- Patient has undergone liver function testing within the past 30 days and meets ALL of the following:
 - Gamma-glutamyl transferase level is less than or equal to 2 times the upper limit of normal; AND
 - Total bilirubin is less than or equal to 2 times the upper limit of normal (unless patient has a diagnosis of Gilbert's syndrome); AND
- Patient does not have left ventricular ejection fraction (LVEF) less than 40%; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Patient does not have an active or recent (within 4 weeks) infection including but not limited to HIV1 and 2, HBV, and HCV; AND
- Dose of Elevidys will be in accordance with the FDA-approved prescribing information and will be administered once per lifetime.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of delandistrogene moxeparvovec-rokl (Elevidys) for patients with a pathogenic variant in the *DMD* gene between exons 1-7, 10-18, or 59-71; who are greater than or equal to 6 years of age, who have received Elevidys or any prior gene therapy, or who have a LVEF less than 40% to be **not medically necessary**.**

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of delandistrogene moxeparvovec-rokl (Elevidys) when the patient selection criteria are not met (except those denoted above as **not medically necessary****) to be **investigational**.*

Background/Overview

Elevidys is a gene therapy indicated for one-time infusion in ambulatory patients greater than or equal to 4 years of age with a confirmed mutation in the *DMD* gene. Elevidys uses an AAV viral vector to deliver a truncated form of the dystrophin gene known as micro-dystrophin to muscle cells. The gene then drives the production of micro-dystrophin in these cells which is theorized to work in place of the missing dystrophin protein. It is contraindicated in patients with any deletion in exon 8 and/or exon 9 in the *DMD* gene due to the increased risk of immune-mediated myositis in these patients. Risk of immune-mediated myositis may also be elevated in patients with mutations in exons 1-17 and 59-71 of the *DMD* gene, but these are not listed as contraindications in the product label.

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DMD is a progressive, X-linked, degenerative neuromuscular disease that results in disabling muscle weakness and eventually leads to early death. It is caused by mutations in the *DMD* gene resulting in reduced or near absence of dystrophin, a protein that helps keep muscle cells intact. Boys with DMD are typically diagnosed at 3-5 years of age, and the estimated U.S. prevalence of DMD ranges from 10,000 to 15,000 males. There is no curative treatment for DMD. Current pharmacological approaches include corticosteroids and exon-skipping therapies. Corticosteroids, such as deflazacort (Emflaza[™])[‡] are the standard of care for treatment of DMD due to their beneficial effects for improving motor function and pulmonary function, reducing the risk of scoliosis, delaying the loss of ambulation, and possibly delaying progression of cardiomyopathy and improving survival. Exon-skipping therapies work to increase dystrophin protein expression in patients that have skippable deletions in exons 51, 53, or 45, representing about 30% of the DMD population. Exon-skipping therapies increase dystrophin protein expression and may at best slow disease progression, but have not been proven to improve survival or functional outcomes.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Elevidys was approved in June 2023 for the treatment of ambulatory pediatric patients aged 4 through 5 years with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the *DMD* gene. In June 2024, the label was updated to include all patients greater than or equal to 4 years of age with a confirmed mutation in the *DMD* gene. In 2025, the label was updated to remove the indication for non-ambulatory patients and add a boxed warning regarding the risk of serious or fatal acute liver injury.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Both the accelerated as well as subsequent traditional approval of Elevidys by the FDA were in contrast to the recommendations made by FDA internal review teams, which did not recommend approval based upon their overall evaluation of the data submitted. The initial decision for accelerated approval was based on a post-hoc subgroup exploratory analysis of North Star Ambulatory Assessment (NSAA) total score in 16 individuals (of the total 41 in Study 102) ages 4 through 5 years and also considered the use of biomarker data from cohort 1 of Study 103 that included 20 ambulatory males aged 4 through 7 years. The subsequent decision for traditional approval was based on a statistically significant difference in three secondary efficacy endpoints, including time to rise from the floor, 10-meter walk/run (10-MWR), and time to ascend 4 steps even though the study failed to meet the primary endpoint of change in NSAA total score from baseline to week 52 post treatment.

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The efficacy of Elevidys was evaluated in two double-blind, placebo-controlled studies (Study 1 and Study 3) and one open-label study (Study 2) in which a total of 214 male patients with a confirmed disease-causing mutation in the *DMD* gene were dosed.

Study 1 is a completed multi-center study including:

- Part 1: a 48-week, randomized, double-blind, placebo-controlled period.
- Part 2: a 48-week period that began following completion of Part 1. Patients who received placebo during Part 1 were treated with Elevidys, and patients treated with Elevidys during Part 1 received placebo.

The study population consisted of male ambulatory DMD patients (n = 41) aged 4 through 7 years with either a confirmed frameshift mutation, or a premature stop codon mutation between exons 18 to 58 in the *DMD* gene.

Patients were randomized 1:1 to receive either Elevidys (n = 20) or placebo (n = 21) as a single intravenous infusion via a peripheral limb. Randomization was stratified by age (i.e., aged 4 to 5 years vs ages 6 to 7 years). In the Elevidys group, eight patients received 1.33×10^{14} vg/kg of Elevidys, and 12 patients received lower doses.

All subjects were on a stable dose of corticosteroids for DMD for at least 12 weeks prior to Elevidys infusion. All randomized subjects had baseline anti-AAVrh74 antibody titers < 1:400 as determined by an investigational total binding antibody ELISA. One day prior to treatment with Elevidys or placebo, the subject's background dose of corticosteroid for DMD was increased to at least 1 mg/kg of a corticosteroid (prednisone equivalent) daily and was continued at this level for at least 60 days after the infusion, unless earlier tapering was clinically indicated.

The primary objectives of Study 1 were to evaluate expression of Elevidys micro-dystrophin in skeletal muscle, and to evaluate the effect of Elevidys on the North Star Ambulatory Assessment (NSAA) total score. The mean change from baseline in the percentage of Elevidys micro-dystrophin compared to control was 43.4 in part 1 and 40.7 in part 2. The change in NSAA total score was assessed from baseline to Week 48 after infusion of Elevidys or placebo. The difference between the Elevidys and placebo groups was not statistically significant (p = 0.37). The least squares (LS) mean changes in NSAA total score from baseline to Week 48 was 1.7 (standard error [SE]: 0.6) points for the Elevidys group and 0.9 (SE:0.6) points for the placebo group. Exploratory subgroup analyses showed that for subjects aged 4 through 5 years, the LS mean changes (SE) in NSAA total score from baseline to Week 48 were 4.3 (0.7) points for the Elevidys group, and 1.9 (0.7) points for the placebo group, a numerical advantage for Elevidys. For subjects aged 6 through 7 years, the LS mean changes (SE) in NSAA total score from baseline to Week 48 were -0.2 (0.7) points for the Elevidys group and 0.5 (0.7) points for the placebo group, a numerical disadvantage for Elevidys.

Study 2 is an ongoing, open-label, multi-center study which includes 5 cohorts of 48 male DMD patients. Patients in cohorts 1, 2, and 3 have a confirmed frameshift mutation, splice site mutation, or premature stop codon mutation anywhere in the *DMD* gene while patients in cohort 4 included those with mutations in the *DMD* gene starting at or after exon 18. All patients in cohort 5 had mutations that partially or fully overlap with exons 1-17 in the *DMD* gene. All subjects had baseline

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anti-AAVrh74 antibodies titers $< 1:400$ as determined by the investigational total binding antibody ELISA and received a single intravenous infusion of 1.33×10^{14} vg/kg Elevidys if they weighed less than 70 kg or 9.31×10^{15} vg/kg total fixed dose if they weighed 70 kg or greater.

The primary objective of the study was to evaluate the effect of Elevidys micro-dystrophin expression as measured by western blot. The mean change from baseline at Week 12 was found to be 51% (standard deviation 47) in ambulatory patients and 40.1% (standard deviation 35.9) in non-ambulatory patients.

Study 3 is a multi-center, randomized, double-blind, placebo-controlled study in which 125 ambulatory male patients aged 4 through 7 years, with a confirmed frameshift, splice site, premature stop codon, or other disease-causing mutation in the *DMD* gene starting at or after exon 18 were dosed. Patients with exon 45 (inclusive), or in-frame deletions, in-frame duplications, and variants of uncertain significance, were excluded. Patients received corticosteroids for DMD before infusion. All patients had baseline anti-AAVrh74 antibodies titers $< 1:400$ as determined by the investigational total binding antibody ELISA and received a single intravenous infusion of 1.33×10^{14} vg/kg Elevidys.

The efficacy outcome measure of the study was to evaluate the effect of Elevidys on physical function as assessed by the NSAA total score. Key secondary outcome measures were to evaluate expression of micro-dystrophin in skeletal muscle, time to rise from floor, and time of 10-meter walk/run. Additional efficacy outcome measures included time of 100-meter walk/run, and time to ascend 4 steps. Results of micro-dystrophin measured by western blot showed a mean micro-dystrophin expression at Week 12 of 34.3% (n=17, SD: 41%) compared to placebo patients of 0% (n = 14, SD: 0%). The change in NSAA total score was assessed from baseline to Week 52 after infusion of Elevidys or placebo. The difference between the Elevidys (n = 63) and placebo groups (n = 61) was not statistically significant (p = 0.24). The least squares (LS) mean changes in NSAA total score from baseline to Week 52 was 2.57 (95% CI: 1.80, 3.34) points for the Elevidys group and 1.92 (95% CI: 1.14, 2.70) points for the placebo group, with a LS mean difference from placebo of 0.65 (95% CI: -0.45, 1.74). Changes of clinical relevance were noted in three secondary efficacy endpoints including time to rise from the floor, 10-meter walk/run, and time to ascend 4 steps.

At Week 52, patients in Study 3 who received placebo were treated with Elevidys and patients who had been treated with Elevidys received placebo. These patients were followed for another two years and compared to an external control annually. At year 2, those treated with Elevidys had significant improvement in NSAA, TTR, and 10MWR compared to the external control group. In the group treated with Elevidys first, the NSAA improvement was 2.88 compared to the external control (p = 0.0001). At year 3, the treatment difference between those treated with Elevidys and the external control continued to increase with an NSAA difference of 4.39 points (p < 0.0002). No new safety signals were observed in the clinical trial.

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References

1. Elevidys [package insert]. Sarepta Therapeutics, Inc. Cambridge, MA. Updated November 2025.
2. Food and Drug Administration. Center Director Decisional Memo for BLA 125781//AMENDMENT 23; Elevidys (delandistrogene moxeparvovec-rokl). Available at <https://www.fda.gov/media/179485/download>
3. Food and Drug Administration. Center Director Decisional Memo for BLA 125781; Elevidys (delandistrogene moxeparvovec-rokl). Available at <https://www.fda.gov/media/169707/download>.
4. Mendell JR, Sahenk Z, Lehman K, et al. Assessment of Systemic Delivery of rAAVrh74.MHCK7.micro-dystrophin in Children With Duchenne Muscular Dystrophy: A Nonrandomized Controlled Trial. JAMA Neurol. Sep 01 2020; 77(9): 1122-1131. PMID 32539076
5. Mendell JR, Sahenk Z, Lehman KJ, et al. Long-term safety and functional outcomes of delandistrogene moxeparvovec gene therapy in patients with Duchenne muscular dystrophy: A phase 1/2a nonrandomized trial. Muscle Nerve. Jan 2024; 69(1): 93-98. PMID 37577753
6. Mendell JR, Shieh PB, McDonald CM, et al. Expression of SRP-9001 dystrophin and stabilization of motor function up to 2 years post-treatment with delandistrogene moxeparvovec gene therapy in individuals with Duchenne muscular dystrophy. Front Cell Dev Biol. 2023; 11: 1167762. PMID 37497476
7. Zaidman CM, Proud CM, McDonald CM, et al. Delandistrogene Moxeparvovec Gene Therapy in Ambulatory Patients (Aged ≥ 4 to 8 Years) with Duchenne Muscular Dystrophy: 1-Year Interim Results from Study SRP-9001-103 (ENDEAVOR). Ann Neurol. Nov 2023; 94(5): 955-968. PMID 37539981
8. Ingram D, Rodino-Klapac LR, Richardson J. SRP-9001-301 PART-1 3-Year Data Topline Results. Sarepta Therapeutics. January 2026.

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02/01/2024 Medical Policy Committee review

02/14/2024 Medical Policy Implementation Committee approval. New policy.

11/07/2024 Medical Policy Committee review

11/13/2024 Medical Policy Implementation Committee approval. Updated coverage statements and background information to reflect full FDA approval for ambulatory patients 4 years of age and older and accelerated approval for non-ambulatory patients.

02/06/2025 Medical Policy Committee Review

02/12/2025 Medical Policy Implementation Committee approval. Updated background information to include summaries of evidence. No change to coverage.

03/05/2026 Medical Policy Committee review

03/11/2026 Medical Policy Implementation Committee approval. Added coverage criteria and updated background information.

Next Scheduled Review Date: 03/2027

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Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)†, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of Louisiana Blue Medical Policy Coverage Guidelines is with Louisiana Blue and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Louisiana Blue Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No codes
HCPCS	J1413
ICD-10 Diagnosis	All related diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);

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2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

****Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.