PRIOR AUTHORIZATION REQUEST

Evrysdi

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	What is the diagnosis or indication? [] Spinal muscular atrophy (treatment) (If checked, go to 2) [] Other (If checked, no further questions)		
2	Does the patient have complete paralysis of all limbs? [If yes, no further questions.]	Yes	No
3	Does the patient have permanent ventilator dependence?	Yes	No

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

	[If yes, no further questions.]		
4	Is the requested medication being prescribed by a neurologist who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders? [If no, no further questions.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a genetic test confirming the diagnosis of spinal muscular atrophy with biallelic mutations in the survival motor neuron 1 (*SMN1*) gene reported as at least ONE of the following: A) Homozygous deletion, B) Homozygous mutation, OR C) Compound heterozygous mutation? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has documentation been submitted to confirm that the patient has two or three survival motor neuron 2 (*SMN2*) gene copies? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 9.]	Yes	No
7	Has documentation been submitted to confirm that the patient has four survival motor neuron 2 (*SMN2*) gene copies? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm that the patient has objective signs consistent with spinal muscular atrophy Types 1, 2, or 3? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Is the patient currently receiving or has the patient received prior treatment with Spinraza (nusinersen intrathecal injection)? [If no, skip to question 11.]	Yes	No
10	Does the prescriber attest that further therapy with Spinraza (nusinersen intrathecal injection) will be discontinued? [If no, no further questions.]	Yes	No
11	Does the prescriber attest that the patient has not received Zolgensma (onasemnogene abeparvovec-xioi intravenous infusion) in the past? [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has had intolerance, contraindication to, or failed treatment with Spinraza (nusinersen intrathecal injection)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Is the patient a female with current reproductive potential? [If no, skip to question 16.]	Yes	No

PRIOR AUTHORIZATION REQUEST

14	Has the prescriber confirmed that the patient is not currently pregnant? [If no, no further questions.]	Yes	No
15	Does the prescriber confirm that effective contraception will be utilized during treatment and until 1 month after the last Evrysdi dose? [If no, no further questions.]	Yes	No
16	Is the patient dependent on invasive ventilation or tracheostomy? [If yes, no further questions.]	Yes	No
17	Is the patient dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep? [If yes, no further questions.]	Yes	No
18	What is the age of the patient? [] 2 months to LESS THAN 2 years of age (If checked, go to 19) [] Greater THAN or equal to 2 years of age (If checked, go to 20) [] Other (If checked, no further questions)		
19	Is the dosing 0.2 mg/kg once daily based on the patient's current (within the past 1 month) kg weight? [If yes, skip to question 23.] [If no, no further questions.]	Yes	No
20	Does the patient weigh GREATER THAN OR EQUAL TO 20 kg? [If no, skip to question 22.]	Yes	No
21	Is the dosing 5 mg once daily? [If yes, skip to question 23.] [If no, no further questions.]	Yes	No
22	Is the dosing 0.25 mg/kg once daily based on the patient's current (within the past 1 month) kg weight? [If no, no further questions.]	Yes	No
23	Is the patient currently receiving the requested medication? [If no, skip to question 28.]	Yes	No
24	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 28.]	Yes	No
25	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered	Yes	No

PRIOR AUTHORIZATION REQUEST

	under initial therapy.] [If yes, skip to question 30.]		
26	Has documentation been submitted to confirm the clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment based on ONE of the following: A) Bayley Scales of Infant and Toddler Development, Third Edition (BSID-III) [Item 22], B) One of the following from Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND): (i) Member exhibited improvement or maintenance of previous improvement of at least a 4- point increase in score or (ii) Member has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so, C) One of the following from Hammersmith Functional Motor Scale Expanded (HFMSE): (i) Member exhibited improvement or maintenance of previous improvement of at least a 3-point increase in score or (ii) Member has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 28.]	Yes	No
27	Has documentation been submitted to confirm the clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment based on ONE of the following: A) Hammersmith Infant Neurological Exam Part 2 (HINE-2) with one of the following: (i) Member exhibited improvement or maintenance of previous improvement of at least a 2 point (or maximal score) increase in ability to kick, or (ii) Member exhibited improvement or maintenance of previous improvement of at least a 1 point (or maximal score) increase in any other HINE-2 milestone (for example, head control, rolling, sitting, crawling, standing, or walking) excluding voluntary grasp; AND one of the following: (i) Member exhibited improvement or maintenance of previous improvement in more HINE-2 motor milestones than worsening (net positive improvement), or (ii) Member achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (for example, sit or stand unassisted, walk), B) Motor Function Measure-32 Items (MFM-32) where patient has experienced an increase in their MFM-32 score from baseline and that increase correlates with a clinically significant functional improvement, C) Revised Upper Limb Module (RULM) test with improvement or maintenance of previous improvement of at least a 2 point increase in score? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Is the patient 2 months of age or older but LESS THAN OR EQUAL TO 25 years of age at the initiation of treatment? [If no, no further questions.]	Yes	No
29	Has documentation been provided to confirm that the patient has had a baseline motor ability assessment that suggests spinal muscular atrophy (based on age, motor ability, and development) from one of the following exams: A) Bayley Scales of Infant and Toddler Development, Third Edition (BSID-III) [Item 22], B) Children's	Yes	No

PRIOR AUTHORIZATION REQUEST

	Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), C) Hammersmith Functional Motor Scale Expanded (HFMSE), D) Hammersmith Infant Neurological Exam Part 2 (HINE-2), E) Motor Function Measure-32 Items (MFM-32), F) Revised Upper Limb Module (RULM) test? ACTION REQUIRED: Submit supporting documentation. [No further questions.]		
30	Was the patient 2 months of age or older but LESS THAN OR EQUAL TO 25 years of age when the requested therapy was started? [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has had a positive clinical response (for example, improvement or stabilization) from pretreatment baseline status (within the past 4 months) with the requested medication in one of the following: A) Bayley Scales of Infant and Toddler Development, Third Edition (BSID-III) [Item 22], B) One of the following from Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND): (i) Member exhibited improvement or maintenance of previous improvement of at least a 4-point increase in score; or (ii) Member has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so, C) One of the following from Hammersmith Functional Motor Scale Expanded (HFMSE): (i) Member exhibited improvement or maintenance of previous improvement of at least a 3-point increase in score; or (ii) Member has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 33.]	Yes	No
32	Has documentation been submitted to confirm that the patient has had a positive clinical response (for example, improvement or stabilization) from pretreatment baseline status (within the past 4 months) with the requested medication in one of the following: A) Hammersmith Infant Neurological Exam Part 2 (HINE-2) with one of the following: (i) Member exhibited improvement or maintenance of previous improvement of at least a 2 point (or maximal score) increase in ability to kick; or (ii) Member exhibited improvement or maintenance of previous improvement of at least a 1 point (or maximal score) increase in any other HINE-2 milestone (for example, head control, rolling, sitting, crawling, standing, or walking) excluding voluntary grasp; AND one of the following: (i) Member exhibited improvement or maintenance of previous improvement in more HINE-2 motor milestones than worsening (net positive improvement); or (ii) Member achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (for example, sit or stand unassisted, walk), B) Motor Function Measure-32 Items (MFM-32) where patient has experienced an increase in their MFM-32 score from baseline and that increase correlates with a clinically significant functional improvement, C) Revised Upper Limb Module (RULM) test with improvement or maintenance of previous improvement of at least a 2 point increase in score? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

33	Has documentation been submitted to confirm that according to the prescriber, the patient has responded to the requested medication and continues to benefit from ongoing therapy by the most recent (within the past 4 months) physician monitoring/assessment tools? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples include pulmonary function tests showing improvement, bulbar function test results suggesting benefits, reduced need for respiratory support, decrease in the frequency of respiratory infections or complications, and/or prevention of permanent assisted ventilation.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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