



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 Is the request for an INITIAL or a CONTINUATION of therapy?

Initial (If checked, go to 7)

Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
 [If no, skip to question 7.]

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Version 04.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	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 under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? <input type="checkbox"/> Spinal muscular atrophy (treatment) (If checked, go to 8) <input type="checkbox"/> Other (If checked, no further questions)		
8	Does the patient have complete paralysis of all limbs? [If yes, no further questions.]	Yes	No
9	Does the patient have permanent ventilator dependence? [If yes, no further questions.]	Yes	No
10	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
11	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 (<i>SMN1</i>) 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
12	Has documentation been submitted to confirm that the patient has two or three survival motor neuron 2 (<i>SMN2</i>) gene copies? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 15.]	Yes	No
13	Has documentation been submitted to confirm that the patient has four survival motor neuron 2 (<i>SMN2</i>) gene copies? ACTION REQUIRED: Submit supporting	Yes	No

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Version 04.2026

PRIOR AUTHORIZATION REQUEST

documentation.

[If no, no further questions.]

- | | | | |
|----|---|-----|----|
| 14 | 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 |
| 15 | Is the patient currently receiving or has the patient received prior treatment with Spinraza (nusinersen intrathecal injection)?
[If no, skip to question 17.] | Yes | No |
| 16 | Does the prescriber attest that further therapy with Spinraza (nusinersen intrathecal injection) will be discontinued?
[If no, no further questions.] | Yes | No |
| 17 | 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 |
| 18 | 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 |
| 19 | Is the patient a female with current reproductive potential?
[If no, skip to question 22.] | Yes | No |
| 20 | Has the prescriber confirmed that the patient is not currently pregnant?
[If no, no further questions.] | Yes | No |
| 21 | Does the prescriber confirm that effective contraception will be utilized during treatment and until 1 month after the last dose of the requested medication?
[If no, no further questions.] | Yes | No |
| 22 | Is the patient dependent on invasive ventilation or tracheostomy?
[If yes, no further questions.] | Yes | No |
| 23 | 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 |
| 24 | What is the age of the patient?
<input type="checkbox"/> LESS THAN 2 months of age (If checked, go to 25)

<input type="checkbox"/> 2 months to LESS THAN 2 years of age (If checked, go to 26)

<input type="checkbox"/> GREATER THAN or equal to 2 years of age (If checked, go to 27) | | |

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Version 04.2026

PRIOR AUTHORIZATION REQUEST

Other (If checked, no further questions)

- | | | | |
|----|--|-----|----|
| 25 | Is the dosing of 0.15 mg/kg once daily based on the patient's current (within the past 1 month) kilogram weight?
[If yes, skip to question 31.]
[If no, no further questions.] | Yes | No |
| 26 | Is the dosing of 0.2 mg/kg once daily based on the patient's current (within the past 1 month) kilogram weight?
[If yes, skip to question 31.]
[If no, no further questions.] | Yes | No |
| 27 | Does the patient weigh GREATER THAN OR EQUAL TO 20 kilograms?
[If no, skip to question 29.] | Yes | No |
| 28 | Is the dosing 5 mg once daily?
[If yes, skip to question 30.]
[If no, no further questions.] | Yes | No |
| 29 | Is the dosing of 0.25 mg/kg once daily based on the patient's current (within the past 1 month) kilograms weight?
[If no, no further questions.] | Yes | No |
| 30 | Is the patient 2 years 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 |
| 31 | 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 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.
[If no, no further questions.] | Yes | No |
| 32 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? | Yes | No |

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

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Version 04.2026



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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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Version 04.2026