PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Evrysdi - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Evrysdi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Evrysdi (risdiplam)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used concurrently with another chronic survival motor neuron (SMN) modifying therapy (e.g. Spinraza [nusinersen]), or gene replacement therapy (e.g. Zolgensma [onasemnogene abeparvovec-xioi]) used for treatment of SMA? Y N

	[If yes, no further questions.]		
2.	Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N	
	[If yes, no further questions.]		
3.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N	
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.		
	[If no, skip to question 6.]		
4.	Is there documentation showing that the patient still does not require invasive ventilation?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Has the patient experienced ONE of the following: A) Reduced decline in motor function, B) Improvement in motor function, OR C) Stabilization of condition?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
6.	Does the patient have a documented diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2, or 3?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Does the patient have Food and Drug Administration (FDA) approved genetic diagnostic testing confirming at least two copies of survival motor neuron 2 (SMN2)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
8.	Does the patient have Food and Drug Administration (FDA) approved genetic diagnostic testing of 5q SMA showing ONE of the following: A) Homozygous gene deletion, B) Homozygous conversion mutation, OR C) Compound heterozygote?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
9.	Is the patient dependent on invasive ventilation or tracheostomy?	Y N	
	[If yes, no further questions.]		
10.	Does the patient have documented signs and symptoms associated with SMA (such as muscle weakness, limited mobility, delayed gross motor skills, difficulty breathing, etc.)?	Y N	
	NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date