TRICARE Prior Authorization Request Form for
risdiplam **(Evrysdi)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial therapy approves for 6 months, renewal approves for 12 months. For renewal of therapy, an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Evrysdi.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. According to the prescriber, has the patient responded to Evrysdi or continues to have benefit from ongoing Evrysdi therapy by an objective measurement and/or assessment tool and/or clinical assessment of benefit? **NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes **Sign and date below** ***Documentation required***	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by a pediatric or adult neurologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have genetic confirmation of homozygous deletion or compound heterozygosity predictive of loss of function of the SMN1 gene? **NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes Proceed to question **5** ***Documentation required***	☐ No **STOP** **Coverage not approved**

5. Does the patient have confirmation of at least two SMN2 gene copies? **NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes Proceed to question **6** ***Documentation required***	☐ No **STOP** **Coverage not approved**
6. For which indication is the medication being prescribed? **NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Spinal Muscular Atrophy Type 0 - **STOP Coverage not approved** ☐ Spinal Muscular Atrophy Type 1 - ***Documentation required*** - Proceed to question **7** ☐ Spinal Muscular Atrophy Type 2 - ***Documentation required*** - Proceed to question **7** ☐ Spinal Muscular Atrophy Type 3 - ***Documentation required*** - Proceed to question **7** ☐ Other **- STOP Coverage not approved**	
7. Does the patient have permanent ventilator dependence?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Does the patient have complete paralysis of all limbs?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Will the medication be used concurrently with Spinraza (nusinersen injection for intrathecal use)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Please provide the patient's weight.	_____ Proceed to question **11**	
11. Please provide the patient's dose in total mg/day and mg/kg per day.	_____ Proceed to question **12**	
12. What is the patient's gender?	☐ Male - Proceed to question **13** ☐ Female - Proceed to question **15**	
13. Is the patient of reproductive potential?	☐ Yes Proceed to question **14**	☐ No **Sign and date below**

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14. Has the patient been counseled about the potential effects on fertility?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Is the patient of childbearing potential?	☐ Yes Proceed to question **16**	☐ No **Sign and date below**
16. Has the patient been counseled to use effective contraception during treatment and for at least 1 month after the cessation of therapy?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____
Prescriber Signature Date

[03 January 2024]

For Internal Use Only:	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: