Zolgensma

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: _______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: _________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>
*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Zolgensma SGM – 11/2021.

Criteria Questions:

1. What is the diagnosis?
   ❑ Spinal muscular atrophy (SMA)
   ❑ Other ____

2. What is the ICD-10 code? _________________

3. Does the patient have a genetically confirmed diagnosis of SMA? ❑ Yes ❑ No

4. Does the patient have bi-allelic mutations in the survival motor neuron 1 (SMN1) gene (deletions or point mutations)? ***ACTION REQUIRED: If Yes, attach genetic testing results demonstrating bi-allelic mutations in the survival motor neuron 1 (SMN1) gene.*** ❑ Yes ❑ No ❑ Unknown

5. Please select which, if any, of the following indicators of advanced spinal muscular atrophy (SMA) the patient has.
   ❑ Complete paralysis of limbs
   ❑ Invasive ventilatory support (tracheostomy)
   ❑ Respiratory assistance for 16 or more hours per day (including non-invasive respiratory support) continuously for 14 or more days in the absence of acute reversible illness (excluding perioperative ventilation)
   ❑ Other indicator(s) of advanced SMA
   ❑ Patient does not have any indicators of advanced SMA

6. Is patient's anti-adeno-associated virus 9 (AAV9) antibody titer less than or equal to 1:50 as determined by an enzyme-linked immunosorbent assay (ELISA) binding immunoassay? ❑ Yes ❑ No

7. Is the medication prescribed by or in consultation with a physician who specializes in treatment of spinal muscular atrophy? ❑ Yes ❑ No

8. Has the patient previously received Zolgensma? ❑ Yes ❑ No

9. Is the patient currently receiving therapy with nusinersen (Spinraza) or risdiplam (Evrysdi)?
   ❑ Yes - Indicate date of last dose: _____________
   ❑ No, *skip to #11*

10. Will nusinersen (Spinraza) or risdiplam (Evrysdi) be discontinued prior to administration of the requested drug?
    ❑ Yes ❑ No

11. Please indicate the anticipated date of administration of the requested medication. ________________ ***(mm/dd/yy)***

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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