

risdiplam (Evrysdi)

USFHP Pharmacy Prior Authorization Form



JOHNS HOPKINS
M E D I C I N E

JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**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):

1 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.	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> 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? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	<input type="checkbox"/> Yes Sign and date below <i>Documentation required</i>	<input type="checkbox"/> No STOP Coverage not approved
3. Please provide the patient's age.	_____ Proceed to question 4	
4. Is the patient's age greater than or equal to 2 months of age to less than or equal to 25 years of age?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the requested medication prescribed by a pediatric or adult neurologist?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved

<p>6. Does the patient have genetic confirmation of homozygous deletion or compound heterozygosity predictive of loss of function of the SMN1 gene?</p> <p>PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<p><input type="checkbox"/> Yes Proceed to question 7 Documentation required</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>7. Does the patient have confirmation of at least two SMN2 gene copies?</p> <p>PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<p><input type="checkbox"/> Yes Proceed to question 8 Documentation required</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>8. For which indication is the medication being prescribed?</p> <p>PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<p><input type="checkbox"/> Spinal Muscular Atrophy Type 0 - STOP Coverage not approved</p> <p><input type="checkbox"/> Spinal Muscular Atrophy Type 1 - Documentation required - Proceed to question 9</p> <p><input type="checkbox"/> Spinal Muscular Atrophy Type 2 - Documentation required - Proceed to question 9</p> <p><input type="checkbox"/> Spinal Muscular Atrophy Type 3 - Documentation required - Proceed to question 9</p> <p><input type="checkbox"/> Spinal Muscular Atrophy Type 4 - STOP Coverage not approved</p> <p><input type="checkbox"/> Other - STOP Coverage not approved</p>	
<p>9. Does the patient have evidence of hepatic impairment?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 10</p>
<p>10. Does the patient have permanent ventilator dependence?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 11</p>
<p>11. Does the patient have complete paralysis of all limbs?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 12</p>
<p>12. Will the medication be used concurrently with Spinraza (nusinersen injection for intrathecal use)?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 13</p>
<p>13. Please provide the patient's weight.</p>	<p>_____</p> <p>Proceed to question 14</p>	

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

14. Please provide the patient's dose in total mg/day and mg/kg per day.	_____ Proceed to question 15	
15. What is the patient's gender?	<input type="checkbox"/> Male - Proceed to question 16 <input type="checkbox"/> Female - Proceed to question 18	
16. Is the patient of reproductive potential?	<input type="checkbox"/> Yes Proceed to question 17	<input type="checkbox"/> No Sign and date below
17. Has the patient been counseled about the potential effects on fertility?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
18. Is the patient of childbearing potential?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> No Sign and date below
19. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 20
20. Has it been confirmed that the patient is not pregnant by (-) HCG?	<input type="checkbox"/> Yes Proceed to question 21	<input type="checkbox"/> No STOP Coverage not approved
21. Has the patient been counseled to use effective contraception during treatment and for at least 1 month after the cessation of therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[16 November 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: