Onasemnogene abeparvovec (Zolgensma)
Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

*Name:	*Specialty:	NPI:	
Address:	City:	State:	Zip:
*Phone #:	Secure Fax #:	Office Contact:	

Primary Diagnosis

*ICD-10 Code: _____

☐Spinal muscular atrophy (SMA), type _____ ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Zolgensma (Onasemnogene abeparvovec)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY - Therapy start date: _____

1. Did patient have onset of symptoms prior to 6 months of age? ☐Yes ☐No
2. Does patient have 1, 2, or 3 copies of the survival motor neuron 2 (SMN2) gene? ☐1 ☐2 ☐3 ☐No
3. Does genetic testing confirm any of the following? ☐Yes ***Mark all that apply*** ☐No
   - ☐Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene)
   - ☐Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7)
   - ☐Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
4. Is therapy prescribed by or in consultation with a neurologist? ☐Yes ☐No
5. Please document one of the following:
   a. Baseline Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score: _____
   b. Baseline Hammersmith Infant Neurological Examination (HINE) motor milestone score: _____
6. Please document ALL of the following:
   a. Patient's weight: _____
   b. Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay: _____
   c. Baseline liver function test:_____, platelet counts:_____, troponin-I:_____
7. Does patient have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence for 16 or more hours per day, tracheostomy, non-invasive ventilation beyond the use for sleep)? ☐Yes ☐No
8. Has patient been previously treated with Zolgensma? ☐Yes ☐No
9. Is Zolgensma prescribed concurrently with Spinraza or Evrysdi? ☐Yes ☐No
10. Is patient currently on Spinraza? ☐Yes ***Submit documentation & mark all that apply*** ☐No
    - ☐Evidence of clinical deterioration upon completion of all loading doses of Spinraza (e.g., sustained decrease in CHOP-INTEND score over a period of 3 to 6 months)
    - ☐Provider attestation of clinical deterioration and Spinraza discontinuation

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peach state health plan

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11. Is patient currently on Evrysdi? ☐ Yes ***Submit documentation & mark all that apply*** ☐ No
☐ Evidence of clinical deterioration upon completion of all loading doses of Spinraza (e.g., sustained decrease in CHOP-INTEND score over a period of 3 to 6 months)
☐ Provider attestation of clinical deterioration and Evrysdi discontinuation

12. Does patient have an active viral infection (e.g., HIV, HBC, HCV, Zika, upper or lower respiratory tract infection)?
☐ Yes ***Mark all that apply*** ☐ No
☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Zika ☐ Upper/lower respiratory tract infection
☐ Non-respiratory tract infection ☐ Other: _____

Complete this section ONLY for indications <u>other</u> than spinal muscular atrophy:

13. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
If yes, submit documentation and answer the following:
a. Please list all previous therapies: _____
b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Physician's Signature _____ Date: _____ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/EPS PA STAFF

Authorization Information

***Authorization number:**	***Decision Due Date:**
***J-Code:**	***Coverage:** ❑ State excludes ❑ COB (secondary)
***Line of Business:** ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare	***Benefit:** ❑ Medical ❑ Pharmacy

***Criteria:**
❑ Centene Policy
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

❑ Medicare Local Coverage Decision (LCD) specific for your region (please include policy of link to LCD)

❑ Medicare National Coverage Decision (NCD) (please include policy of link to NCD)