peach state health plan

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 the following patient information:
   a. Patient's weight: ______________ kg
   b. Baseline Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score: _________
   c. Baseline Hammersmith Infant Neurological Examination (HINE) motor milestone score: _________
   d. Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay: _________
   e. Baseline liver function test:______________, platelet counts:______________, troponin-I:______________
6. 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
7. Has patient been previously treated with Zolgensma? ☐Yes ☐No
8. Is Zolgensma prescribed concurrently with Spinraza or Evrysdi? ☐Yes ☐No
9. 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

Please continue to page 2.

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Patient Name: ____ **DOB:** ____________________

10. 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
11. 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 other than spinal muscular atrophy:

12. 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 COMPLETED BY THE HEALTH PLAN / CPS 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 [**CP.PHAR.421 Onasemnogene Abeparvovec (Zolgensma)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):
____

☐ State of Health Plan specific (please include policy)

☐ Medicare Local Coverage Decision (LCD) specific for your region.
Please include policy of link to LCD, followed by any applicable step therapy requirements.

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable step therapy requirements.