Onasemnogene abeparvovec (Zolgensma)
Prior Authorization Form/Prescription

peach state health plan

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. Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay: _____
   b. 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

Please continue to page 2.

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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)