

Zolgensma® (onasemnogene abeparvovec-xioi) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)The NDC for this weight-based medication is specific to the dose required. The NDC should reflect the member's current weight.

Projected Date of Infusion: _____ Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Name of outpatient hospital facility where Spinraza will be delivered to and administered at:
_____**Prescriber Information**

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria***Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.****For Authorization: (only 1 infusion will be approved per member per lifetime)**

1. If not previously submitted, please provide the member's recent progress notes discussing respiratory status.
2. What is the member's diagnosis?

 Spinal Muscular Atrophy (SMA)A. Has the diagnosis been confirmed by molecular genetic testing? Yes No

i. If yes, please submit results of genetic testing.

B. Does member have biallelic pathogenic variants in the survival motor neuron gene 1 (SMN1)?

Yes No **Other:** _____

3. Will member have reached full-term gestational age prior to the "Projected Date of Infusion" provided in the Drug Information section of this form? Yes No

4. Is member currently dependent on permanent invasive ventilation? Yes No

If member requires ventilator support, please provide a recent nursing note stating hours on the ventilator per day.

A. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: _____

B. If member is currently dependent on permanent ventilation, how many continuous days has member required ventilator support? _____

C. Has the member required ventilator support in the absence of an acute, reversible illness or a perioperative state? Yes No

5. Is Zolgensma® prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA)? Yes No

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Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

***Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.**

For Authorization: (continued)

6. Please provide member's baseline anti-AAV9 antibody titers: _____
7. Does prescriber agree to monitor liver function tests and platelet counts at baseline and as directed by the Zolgensma® prescribing information? Yes No
8. Does prescriber agree to administer systemic corticosteroids starting 1 day prior to the Zolgensma® infusion and continue as recommended in the prescribing information based on member's liver function? Yes No
9. Will the facility where Zogensma® will be delivered to and administered at, and pharmacy if applicable, adhere to the storage and handling requirements in the Zolgensma® prescribing information? Yes No
10. Is member currently receiving treatment with Spinraza®? Yes No
11. Is member currently receiving treatment with Evrysdi®? Yes No
12. Will Spinraza® or Evrysdi® treatment be used concomitantly with Zolgensma®? Yes No
13. Please provide member's current weight: _____ Date taken: _____

Additional Information: _____

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Prescriber Signature: _____ **Date:** _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) **Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.**

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