

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**  
**DUR MEDICATION EVRYSDI™ (risdiplam)**  
**Fax back to: 1-855-799-2553**

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**DRUG INFORMATION**

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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For initial approval, complete the following questions to receive a 1-year approval:

1. Does the member have a confirmed diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA) confirmed by either homozygous deletion of the SMN1 gene or dysfunctional mutation of the SMN1 gene? **AND**

Yes     No

2. Is there confirmation that the member has one of the following phenotypes?

- a. SMA type 1 confirmed by one of the following:

The member must have 1 to 2 copies of the SMN2 gene; **OR**

The member has 3 copies of the SMN2 gene in the absence of the c.859G>C single base substitution modification in exon 7; **OR**

- b. SMA type 2 with symptomatic disease (e.g., impaired motor function and/or delayed motor milestones); **OR**

- c. SMA type 3 with symptomatic disease (e.g., impaired motor function and/or delayed motor milestones); **AND**

Yes     No

3. Is there confirmation that the member does NOT require invasive ventilation or tracheostomy? **AND**

Yes     No

4. Is there confirmation that risdiplam is NOT being used concomitantly with nusinersen (Spinraza®) or onasemnogene abeparvovec-xioi (Zolgensma®)? **AND**

Yes     No

5. Is there confirmation that the member has NOT previously received onasemnogene abeparvovec-xioi (Zolgensma)? **AND**

Yes     No

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

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6. Is there confirmation that the member has a baseline documentation of  $\geq 1$  of the following?
- a. Motor function/milestones, including but NOT limited to, the following validated scales: Hammersmith Infant Neurologic Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), 6-minute walk test (6MWT), upper limb module (ULM), etc.; **OR**
  - b. Respiratory function tests (e.g., forced vital capacity [FVC]); **OR**
  - c. Exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe.

Yes       No

**For renewal, complete the following questions to receive a 1-year approval:**

7. Does the member continue to meet the above criteria? **AND**

Yes       No

8. Is the member absent of unacceptable toxicity or treatment related adverse event from the drug? **AND**

Yes       No

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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9. Has the member experienced a clinically meaningful response to treatment as demonstrated by  $\geq 1$  of the following?

- a. Stability or improvement in net motor function/milestones, including but not limited to, the following validated scales: Hammersmith Infant Neurologic Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Bayley Scales of Infant and Toddler development Third Edition (BSID-III), 6-minute walk test (6MWT), upper limb module (ULM), etc.; **OR**
- b. Stability or improvement in respiratory function tests (e.g., forced vital capacity [FVC]); **OR**
- c. Reduction in exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe; **OR**
- d. Slowed rate of decline in the aforementioned measures.

Yes       No

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.