Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Evrysdi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the prescribed dose follow the recommended dosing per Evrysdi™ (risdiplam) prescribing information?

☐ Yes ☐ No

Q2. Select dosing that is being prescribed:

☐ Oral Solution - Under 2 months of age, dose does not exceed 0.15 mg/kg per day

☐ Oral Solution - 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day

☐ Oral Solution - 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day

☐ Oral Solution - 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

☐ 5 mg tablet - 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

Q3. Is the medication prescribed by or in consultation with a neurologist or physician who specializes in treatment of spinal muscular atrophy?

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☐ Yes ☐ No

Q4. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

☐ Yes ☐ No

Q5. Request Type:

☐ Initial - Go to 6 ☐ Renewal - Go to 9

Q6. Does the member have a diagnosis of spinal muscular atrophy type I, II, or III?

☐ Yes ☐ No

Q7. Is the patient's diagnosis of spinal muscular atrophy confirmed by laboratory documentation of homozygous deletion or mutation of SMN 1 gene?

☐ Yes ☐ No

Q8. Select the criteria that applies:

☐ Member is not concurrently being treated with gene therapy, including Spinraza® and/or Zolgensma®, or currently enrolled in a clinical trial to receive gene therapy for SMA

☐ Member previously received gene therapy and was unable to maintain beneficial response in SMA-associated symptoms as documented by chart notes

Q9. Does the patient continue to meet the diagnostic criteria?

☐ Yes ☐ No

Q10. Is the patient receiving clinical benefit based on the prescriber's assessment?

☐ Yes ☐ No

Q11. Does the patient have the absence of unacceptable toxicity which precludes safe administration of the drug?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q12. Additional Information:	

Prescriber Signature _____ Date _____

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