HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Evrysdi - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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. Is this a renewal request? If YES, go to 8. If NO, go to 2.

☐ Yes ☐ No

Q2. Is the medication prescribed by or in consultation with a neurologist or physician who specializes in treatment of spinal muscular atrophy?

☐ Yes ☐ No

Q3. Does the member have a diagnosis of spinal muscular atrophy type I, II, or III?

☐ Yes ☐ No

Q4. Is the patient's diagnosis of spinal muscular atrophy confirmed by the following?

. Laboratory documentation of homozygous deletion or mutation of SMN 1 gene

☐ Yes ☐ No

Q5. Does the prescribed dose follow the recommended dosing per Evrysdi (risdiplam) prescribing information as described below?

Oral Solution:

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Member Name:	Prescriber Name:

. If under 2 months of age, dose does not exceed 0.15 mg/kg per day
. If 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day
. If 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day
. If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

5 MG Tablet:
. If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

☐ Yes ☐ No

Q6. Does the patient meet at least one of the following criteria?

. 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

☐ Yes ☐ No

Q7. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

☐ Yes ☐ No

Q8. Is the medication prescribed by or in consultation with a neurologist or physician who specializes in treatment of spinal muscular atrophy?

☐ Yes ☐ No

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 receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q12. Does the prescribed dose follow the recommended dosing per Evrysdi (risdiplam) prescribing information as described below?

Oral Solution:
. If under 2 months of age, dose does not exceed 0.15 mg/kg per day
. If 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day
. If 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day
. If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

5 MG Tablet:
. If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

☐ Yes ☐ No

Q13. Does the patient have the absence of unacceptable toxicity which precludes safe administration of the drug?

☐ Yes ☐ No

Q14. Additional Information:

_____ _____

Prescriber Signature Date

v2026