



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Evryski

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, 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 the medication prescribed by or in consultation with a neurologist or physician who specializes in treatment of spinal muscular atrophy?

Yes No

Q2. Does the prescribed dose follow the recommended dosing per Evryski (risdiplam) prescribing information as described below?

- A) If 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day,
B) If 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day, OR
C) If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day.

Yes No

Q3. Is this a renewal?

If Yes, go to 9.

Yes No

Q4. Does the member have a diagnosis of spinal muscular atrophy type I, II, or III?

Yes No

Q5. 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

Q6. Is the patient greater than or equal to two months of age?

Yes No

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Patient Name: Prescriber Name:

Q7. Does the patient meet at least one of the following criteria?

A) 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, OR

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

Go to 13.

Yes checkbox

No checkbox

Q8. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

Yes checkbox

No checkbox

Q9. For Renewal, does the patient continue to meet the diagnostic criteria?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q11. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

Yes checkbox

No checkbox

Q12. Does the patient have the absence of unacceptable toxicity which precludes safe administration of the drug?

Yes checkbox

No checkbox

Q13. Additional Information:

Yes checkbox

No checkbox

Prescriber Signature

Date

Updated for 2021