Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Evrysdi

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient 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 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 Evrysdi™ (risdiplam) prescribing information as described below?
A) If under 2 months of age, dose does not exceed 0.15 mg/kg per day
B) If 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day,
C) If 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day, OR
D) 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 8.

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

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Patient Name:	Prescriber Name:

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.

☐ Yes ☐ No

Q7. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy? If YES, go to 12.

☐ Yes ☐ No

Q8. For Renewal, does the patient continue to meet the diagnostic criteria?

☐ Yes ☐ No

Q9. Is the patient receiving clinical benefit based on the prescriber's assessment?

☐ Yes ☐ No

Q10. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q12. Additional Information:

☐ Yes ☐ No

Prescriber Signature _____ Date _____

Updated for 2023

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