Evrysdi (risdiplam)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Pre-Symptomatic Spinal Muscular Atrophy (SMA)** ☐ **Type 1 Spinal Muscular Atrophy (SMA)** ☐ **Type 2 or 3 Spinal Muscular Atrophy (SMA)** ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is request for tablets ? ☐ **Yes** ☐ **No**
Is request for oral solution? ☐ **Yes** ☐ **No**

Pre-Symptomatic SMA:

Is patient aged from birth (1 day) to 6 weeks (42 days) of age? □ **Yes** □ **No** (please provide documentation)

Is patient a gestational age of 37-42 weeks for singleton births; gestational age of 34-42 weeks for twins? □ **Yes** □ **No** (please provide documentation)

Does patient have a body weight >= 3rd percentile for age? □ **Yes** □ **No** (please provide documentation)

Does patient have a genetic diagnosis of 5q-autosomal recessive SMA? □ **Yes** □ **No** (please provide documentation)

Does patient have confirmation of homozygous deletion or compound heterozygosity predictive of loss of function of the SMN1 gene? □ **Yes** □ **No** (please provide documentation)

Does patient have clinical signs or symptoms of SMA at screening that are strongly suggestive of SMA? □ **Yes** □ **No** (please provide documentation)

Has the patient received any previous treatment of SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier, cell therapy or gene therapy (such as Zolgensma or Spinraza)? □ **Yes** □ **No** (please provide documentation)

Does the patient require invasive ventilation, tracheostomy or awake non-invasive ventilation? □ **Yes** □ **No** (please provide documentation)

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Does patient have awake hypoxemia (SaO2 < 95%) with or without ventilator support? □ **Yes** □ **No** (please provide documentation)

SMA Type 1:

Was the patient born at a gestational age of 37 to 42 weeks, inclusive? □ **Yes** □ **No** (please provide documentation)

Does the patient have a clinical history, signs or symptoms attributable to Type 1 SMA with onset after age 28 days but prior to the age of 3 months? □ **Yes** □ **No** (please provide documentation)

Does the patient have a confirmed diagnosis of 5q-autosomal recessive SMA?
□ **Yes** □ **No** (please provide documentation)

Does the patient have two survival motor neuron 2 (SMN2) gene copies?
□ **Yes** □ **No** (please provide documentation)

Is the patient's body weight greater than or equal to the third percentile for age? □ **Yes** □ **No**

Has the patient received any previous treatment of SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier, cell therapy or gene therapy (such as Zolgensma or Spinraza)? □ **Yes** □ **No**

Does the patient require invasive ventilation or tracheostomy? □ **Yes** □ **No**

SMA Type 2 or SMA Type 3:
Does the patient have a confirmed diagnosis of 5q-autosomal recessive SMA?
□ **Yes** □ **No** (please provide documentation)

Has the patient received any previous treatment of SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier, cell therapy or gene therapy (such as Zolgensma or Spinraza) □ **Yes** □ **No**

Is the patient ambulatory? □ **Yes** □ **No**

Is the patient able to raise one or both hands to his/her own mouth? □ **Yes** □ **No**

Is the patient able to sit independently? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form. **Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____
CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
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St. Paul, MN 55164-0811
Phone: 877-228-7909