

**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](http://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:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page*

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<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b>		<b>ICD-10:</b>
<input type="checkbox"/> Spinal Muscular Atrophy (SMA) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b>  <p>Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b><u>SMA Type 1</u></b></p> <p>Was the patient born at a gestational age of 37 to 42 weeks, inclusive? <input type="checkbox"/> Yes <input type="checkbox"/> No (please provide documentation)</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No (please provide documentation)</p> <p>Does the patient have a confirmed diagnosis of 5q-autosomal recessive SMA?  <input type="checkbox"/> Yes <input type="checkbox"/> No (please provide documentation)</p> <p>Does the patient have two survival motor neuron 2 (SMN2) gene copies?  <input type="checkbox"/> Yes <input type="checkbox"/> No (please provide documentation)</p> <p>Is the patient's body weight greater than or equal to the third percentile for age? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient require invasive ventilation or tracheostomy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b><u>SMA Type 2 or SMA Type 3</u></b></p> <p>Does the patient have a confirmed diagnosis of 5q-autosomal recessive SMA?  <input type="checkbox"/> Yes <input type="checkbox"/> No (please provide documentation)</p> <p>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) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

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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  
P.O. Box 64811  
St. Paul, MN 55164-0811