**FAX Completed Form To**
1.833.404.2392
**Pharmacy Help Desk**
1.800.460.8988
**Prescriber Help Desk**
1.833.587.2012

# Request for Prior Authorization
# RISDIPLAM (EVRYSDI)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

| | | |
|---|---|---|
| IA Medicaid Member ID # | Patient name | DOB |
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| Pharmacy NPI | Pharmacy fax | NDC |

**Prior authorization (PA) is required for risdiplam (Evrysdi). Payment will be considered under the following conditions:**

1) **Patient has a diagnosis of spinal muscular atrophy (SMA); and**
2) **Patient meets the FDA approved age for diagnosis; and**
3) **Dosing follows FDA approved dose for age and weight; and**
4) **A negative pregnancy test for females of reproductive potential prior to initiating treatment; and**
5) **Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least 1 month after last dose and male patients of reproductive potential have been counseled on the potential effects on fertility; and**
6) **Patient does not have impaired liver function; and**
7) **Will not be prescribed concomitantly with other SMA treatments, such as Spinraza (nusinersen), Zolgensma (onasemnogene abeparvovec), or any other new products that are approved by the FDA and released: and**
8) **Documentation of previous SMA therapies and response to therapy is provided; and**
   a. **For patients currently on Spinraza, documentation Spinraza will be discontinued is provided, including date of last dose, and the appropriate interval based on the dosing frequency of the other drug has been met (i.e. 4 months from the last dose when on maintenance therapy); or**
   b. **For patients treated with Zolgensma, requests will not be considered: and**
9) **Is prescribed by or in consultation with a neurologist: and**
10) **Pharmacy will educate the member, or member's caregiver, on the storage and administration of Evrysdi, as replacements for improper storage or use will not be authorized.**

**If the criteria for coverage are met, requests will be approved for 1 year. Requests for continuation of therapy will require documentation of a positive response to therapy including stabilization or improved function unless intercurrent event (fracture, illness, other) affects functional testing.**

**Non-Preferred**

☐ Evrysdi

| Strength | Dosage Instructions | Quantity | Days Supply |
|---|---|---|---|
| | | | |

**Diagnosis:** _____

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## Request for Prior Authorization-*Continued*
## RISDIPLAM (EVRYSDI)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Patient's current weight (kg): _____**

**If female of reproductive potential, confirmed negative serum pregnancy test?** ❑ Yes Date: _____ ❑ No

**If female of reproductive potential, has patient been advised to use effective contraception during treatment and for at least 1 month after last dose?** ☐ Yes ☐ No

**If male of reproductive potential, has patient been counseled on the potential effects on fertility?** ☐ Yes ☐ No

**Does patient have impaired liver function?** ☐ Yes ☐ No

**Is Evrysdi being prescribed concomitantly with other SMA treatments (Spinraza, Zolgensma, or other new products)?** ☐ Yes ☐ No

**Previous SMA therapies:**
☐ Spinraza

Trial dates: _____ Date of last dose : _____

Response to therapy: _____

Has Spinraza been discontinued? ☐ Yes ☐ No

☐ Zolgensma

Trial dates: _____

Response to therapy: _____

**Is prescriber a neurologist?** ☐ Yes ☐ No

**Has education been provided on the storage and administration of Evrysdi?** ☐ Yes ☐ No

**<u>Renewal Requests</u>**

Provide documentation of positive response to therapy including stabilization or improved function unless intercurrent event affects functional testing:

_____

_____

_____

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|
| | |

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*