South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Evrysdi® Prior Authorization Request Form (Page 1 of 3)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Spinal muscular atrophy (SMA): Type _____

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

1. Select if the requested medication is prescribed by or in consultation with one of the following specialists:
   - ❑ Neurologist with expertise in the diagnosis and treatment of SMA
   - ❑ Other _____
2. How many SMN2 copies? _____
3. Does the mutation or deletion of genes in chromosomes 5q result in the following:
   - ❑ Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) _____
   - ❑ Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) _____
   - ❑ Other _____
4. Is the patient dependent on invasive ventilation or tracheostomy? ❑ **Yes** ❑ **No**
5. Is the patient dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep? ❑ **Yes** ❑ **No**
6. Has one of the other exams listed below (based on patient's age and motor ability) been conducted to establish baseline motor ability by a board-certified neurologist?
   - ❑ Hammersmith Functional Motor Scale Expanded (HFMSE)
   - ❑ Hammersmith Infant Neurological Exam (HINE) (infant to early childhood)
   - ❑ Upper Limb Module (ULM) Test (Non ambulatory)
   - ❑ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
   - ❑ Motor Function Measure 32 (MFM-32) Scale
7. Is the patient on concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza)?
   ❑ **Yes** ❑ **No**
8. Has the patient previously received gene replacement therapy for the treatment of SMN (e.g., Zolgensma)? ❑ **Yes** ❑ **No**

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9. If patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma), provider to attests that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months) or worsening in clinical status since receiving gene therapy as demonstrated by a decline of minimally clinical important difference fro highest score achieved on one of the following exams:
   - ❑ HFMSE: decline of at least _____ points on kicking and _____ points on any other milestones (excluding voluntary grasp)
   - ❑ HINE-2: decline of at least _____ points
   - ❑ CHOP INTEND: decline of at least _____ points

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Reauthorization:
If this is a reauthorization request, answer the following:

1. How many SMN2 copies? _____

2. Provide documentation of positive clinical response to therapy (e.g., chart notes, laboratory values) from pretreatment baseline status as demonstrated by the most recent results (less than 1 month prior to reauthorization request) from one of the following exams:
   - ❑ One of the following HINE-2 milestones _____
     - ❑ Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick
     - ❑ Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp
     - ❑ Patient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
     - ❑ Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following HFMSE milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 3-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following ULM test milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 2-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following CHOP-INTEND milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 4-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following MFM-32 milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 3-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

3. Is the patient dependent on invasive ventilation or tracheostomy? ❑ **Yes** ❑ **No**

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4. Is the patient dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep? ❑ **Yes** ❑ **No**
5. Is the requested medication prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA? ❑ **Yes** ❑ **No**
6. Is the patient is receiving concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza)? ❑ **Yes** ❑ **No**
7. Has the patient previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma)? ❑ **Yes** ❑ **No**
8. Was there inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months)? If so, submit medical records (e.g., chart notes) documenting the inadequate response to gene therapy.

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.