SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: EVRYSDI™ (risdiplam)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA/DIAGNOSIS: Check below all that apply. All criteria/diagnosis must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization Approval: 1 year

1. Is the member 2 months of age or older? **AND**
   - ❑ Yes ❑ No
2. Does the member have a confirmed diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA) confirmed by either homozygous deletion of the SMN1 gene or dysfunctional mutation of the SMN1 gene? **AND**
   - ❑ Yes ❑ No

(Continued on next page)

3. Is there confirmation that the member has one of the following phenotypes?
   a. SMA type 1 confirmed by one of the following:
      - ❑ The member must have 1 to 2 copies of the SMN2 gene; **OR**
      - ❑ The member has 3 copies of the SMN2 gene in the absence of the c.859G>C single base substitution modification in exon 7; **OR**
   b. SMA type 2 with symptomatic disease (e.g., impaired motor function and/or delayed motor milestones); **OR**
   c. SMA type 3 with symptomatic disease (e.g., impaired motor function and/or delayed motor milestones); **AND**

   ❑ Yes ❑ No
4. Is there confirmation that the member does NOT require invasive ventilation or tracheostomy? **AND**

   ❑ Yes ❑ No
5. Is there confirmation that risdiplam is NOT being used concomitantly with nusinersen (Spinraza®) or onasemnogene abeparvovec-xioi (Zolgensma®)? **AND**

   ❑ Yes ❑ No
6. Is there confirmation that the member has NOT previously received onasemnogene abeparvovec-xioi (Zolgensma®)? **AND**

   ❑ Yes ❑ No
7. Is there confirmation that the member has a baseline documentation of ≥ 1 of the following? (Please submit the actual assessment)
   a. Motor function/milestones, including but NOT limited to, the following validated scales: Hammersmith Infant Neurologic Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), 6-minute walk test (6MWT), upper limb module (ULM), etc.; **OR**
   b. Respiratory function tests (e.g., forced vital capacity [FVC]); **OR**
   c. Exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe.

   ❑ Yes ❑ No

Reauthorization Approval: 1 year. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

8. Does the member continue to meet the above criteria? **AND**

   ❑ Yes ❑ No
9. Is the member absent of unacceptable toxicity or treatment related adverse event from the drug? **AND**

   ❑ Yes ❑ No

(Continued on next page)

10. Has the member experienced a clinically meaningful response to treatment as demonstrated by ≥ 1 of the following?
    a. Stability or improvement in net motor function/milestones, including but not limited to, the following validated scales: Hammersmith Infant Neurologic Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Bayley Scales of Infant and Toddler development Third Edition (BSID-III), 6-minute walk test (6MWT), upper limb module (ULM), etc.; **OR**
    b. Stability or improvement in respiratory function tests (e.g., forced vital capacity [FVC]); **OR**
    c. Reduction in exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe; **OR**
    d. Slowed rate of decline in the aforementioned measures.

    ❑ Yes ❑ No

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.