CareSource Rxinnovations

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT**
**SPINAL MUSCULAR ATROPHY AGENTS PRIOR AUTHORIZATION REQUEST FORM**

*CareSource Pharmacy Prior Authorization Form*
**P.O. Box 8738**
**Dayton, OH 45401-8738**
**Fax: (866) 930-0019**

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

**Note:** This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

| | |
|---|---|
| Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐ | Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # ☐☐☐☐☐☐☐☐ | Specialty |
| Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐ | Office Contact |
| Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐ | Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐ |
| Prescriber's Address | Date(s) of Service: _____<br>Start Date: _____ |

| Requested Medication | Strength | Quantity | Directions for Use |
|---|---|---|---|
| | | | |

I attest that the information is accurate:

**Physician Signature:** _____ **Date:** _____

## Evrysdi PA Requirements

1. **Diagnosis (please choose one):** Diagnosis Code: _____
   - ☐ Spinal muscular atrophy (SMA) with zero copies of SMN1 or chromosomal mutations producing SMN protein deficiency AND no more than 4 copies of SMN2 (please include documentation)
   - ☐ SMA with symptoms onset before 6 months of age (please include documentation)

2. **Member's current weight:** _____
   Requested dose:
   - ☐ 5 mg daily for adults and children 2 years of age and older weighing more than 20kg
   - ☐ 0.25 mg/kg/dose daily for children 2 to 12 years of age weighing less than 20kg
   - ☐ 0.2 mg/kg/dose daily for infants and children 2 months to less than 2 years of age
   - ☐ 0.15 mg/kg/dose daily for infants less than 2 months of age

3. **Prescriber has conducted testing to determine current clinical status and submitted documentation with prior authorization request (e.g., CHOP intend, HINE-2, HFMS, 6-minute walk test, etc.)**
   ☐ Yes ☐ No

4. **Patient has received prior treatment with Zolgensma (onasemnogene-abeparvovec-xioi)** ☐ Yes ☐ No

## Spinraza PA Requirements

1. **Diagnosis (please choose one):** Diagnosis Code: _____

   ☐ Spinal muscular atrophy (SMA) with zero copies of SMN1 or chromosomal mutations producing SMN protein deficiency AND no more than 3 copies of SMN2 (please include documentation)

   ☐ SMA with symptoms onset before 6 months of age (please include documentation)

2. **Requested dose:**

   ☐ **Loading dose:** 12 mg intrathecally every 14 days for three doses, followed by a fourth dose 30 days after the third dose

   ☐ **Maintenance dose:** 12 mg intrathecally every 4 months

3. **Prescriber has conducted testing to determine current clinical status and submitted documentation with prior authorization request (e.g., CHOP intend, HINE-2, HFMS, 6-minute walk test, etc.)**

   ☐ Yes ☐ No

4. **Patient has received prior treatment with Zolgensma (onasemnogene-abeparvovec-xioi)** ☐ Yes ☐ No