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



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



Today's Date						
/ / / / / / / / / / / / / / / / / / /	Non-U	rgent	Urgent			
Note: This form must be completed by the prescribing provider.  ***All sections must be completed or the request will be returned.***						
Member's CareSource #		Member's Date of Birth / / / /				
Member's Name		Prescriber's Name				
Prescriber's Indiana License #	Specialty	Specialty				
Prescriber's NPI #	Office Contact					
Prescriber's Fax -	Prescriber's Pho	Prescriber's Phone				
Prescriber's Address	Date(s) of Service Start Date:	Date(s) of Service:Start Date:				
Requested Medication	Strength	Quantity	Direction	s for Use		
I attest that the information is accur	rate:					
Physician Signature:			Date:			
Physician Signature:			Date:	_		
Physician Signature:  Evrysdi PA Requirements			Date:	_		
			Date:	_		
<ul><li>Evrysdi PA Requirements</li><li>1. Diagnosis (please choose on SMA with zero copies of SI</li></ul>	ne): MN1 or chromosom	<b>Diagnosis Coo</b> al mutations produ	le:			
Diagnosis (please choose on SMA with zero copies of SMM more than 4 copies of SMM)	ne): MN1 or chromosom N2 (please include d	<b>Diagnosis Coc</b> al mutations produ locumentation)	le:cing SMN protein def			
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Diagnosis (please choose on SMA with zero copies of SMM more than 4 copies of SMM)	ne): MN1 or chromosom N2 (please include d before 6 months of	Diagnosis Cod al mutations produ locumentation) age (please includ	le:cing SMN protein defi	iciency AND no		
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## **Evrysdi PA Requirements (continued)**

Note: If member was previously treated with Zolgensma (onasemnogene-abeparvovec-xioi, prescriber must submit documentation illustrating evidence of decline post Zolgensma treatment. In addition, a copy of a Medwatch report documenting Zolgensma treatment failure must be submitted to the FDA and to the plan. Medwatch form: <a href="https://www.FDA.gov/media/76299/download">www.FDA.gov/media/76299/download</a>

Spinraza PA Requirements				
1.	Diagnosis (please choose one):     Diagnosis Code:			
	<ul> <li>Spinal muscular atrophy (SMA) with zero copies of SMN1 or chromosomal mutations proportion deficiency AND no more than 3 copies of SMN2 (please include documentation)</li> <li>SMA with symptoms onset before 6 months of age (please include documentation)</li> </ul>	oducing SMN		
2.	2. Requested dose:			
	<ul> <li>Loading dose: 12 mg intrathecally every 14 days for three doses, followed by a fourth do the third dose</li> <li>Maintenance dose: 12 mg intrathecally every 4 months</li> </ul>	ose 30 days after		
3.	3. Prescriber has conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing to determine current clinical status and submitted conducted testing test			
4.	4. Patient has received prior treatment with Zolgensma (onasemnogene-abeparvovec-xie	oi) □Yes □ No		
	Note: If member was previously treated with Zolgensma (onasemnogene-abeparvovec-must submit documentation illustrating evidence of decline post Zolgensma treatment. It of a Medwatch report documenting Zolgensma treatment failure must be submitted to the plan. Medwatch form: <a href="https://www.FDA.gov/media/76299/download">www.FDA.gov/media/76299/download</a>	n addition, a copy		

## **CONFIDENTIAL INFORMATION**

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at 1-844-607-2831.