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

CareSource RxInnovations

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.*****

Member's CareSource #	Member's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Member's Name	Prescriber's Name
Prescriber's Indiana License #	Specialty
Prescriber's NPI #	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ 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:** _____
   - ☐ 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:** _____ KG/LB (please circle one)
   Requested dose:
   - ☐ 5 mg daily for adults and children 2 years of age and older weighing more than 20 kg
   - ☐ 0.25 mg/kg/dose daily for children 2 to 12 years of age weighing less than 20 kg
   - ☐ 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, six minute walk test, etc.)?**
   ☐ Yes ☐ No

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

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: www.FDA.gov/media/76299/download

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, six minute walk test, etc.)**

   ☐ Yes ☐ No

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

   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: www.FDA.gov/media/76299/download