# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Zolgensma® Prior Authorization Request Form

**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: (and attach supporting documentation to the PA request)**

- ❑ The recipient has a diagnosis of symptomatic Type I or Type II Spinal Muscular Atrophy (SMA) confirmed by a neurologist with expertise in the diagnosis of SMA
- ❑ The recipient has a diagnosis of Spinal Muscular Atrophy (SMA) based on the results of SMA newborn screening with three copies or fewer of Survival Motor Neuron 2 (SMN2)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical information: (attach any other information the physician feels is important to this review)**

Is the recipient 2 years of age or younger? ❑ **Yes** ❑ **No**

Is the recipient dependent on invasive ventilation or tracheostomy or on non-invasive ventilation beyond use for naps and nighttime sleep? ❑ **Yes** ❑ **No**

Does the recipient have homozygous gene deletion or mutation of the Survival Motor Neuron 1 (SMN1) gene (e.g., homozygous deletion of exon 7 at locus 5q13)? ❑ **Yes** ❑ **No**

Does the recipient have compound heterozygous mutation of the SMN1 gene (e.g., deletion of SMN1, exon 7 [allele 1] and mutation of SMN1 [allele 2])? ❑ **Yes** ❑ **No**

Will the recipient's medical records (e.g., chart notes, laboratory values) be submitted documenting that the recipient's anti-AAV9 antibody titers are less than or equal to 1:50? ❑ **Yes** ❑ **No**

Will the recipient receive concomitant SMN modifying therapy (e.g., Spinraza®)? ❑ **Yes** ❑ **No**

Is the medication prescribed by a neurologist with expertise in the diagnosis of SMA? ❑ **Yes** ❑ **No**

Has the recipient ever received Zolgensma® treatment in their lifetime? ❑ **Yes** ❑ **No**

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.