



# 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:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below: (and attach supporting documentation to the PA request)</b>					
<input type="checkbox"/> 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					
<input type="checkbox"/> 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)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical information: (attach any other information the physician feels is important to this review)</b>					
Is the recipient 2 years of age or younger? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the recipient dependent on invasive ventilation or tracheostomy or on non-invasive ventilation beyond use for naps and nighttime sleep? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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])? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will the recipient receive concomitant SMN modifying therapy (e.g., Spinraza®)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the medication prescribed by a neurologist with expertise in the diagnosis of SMA? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the recipient ever received Zolgensma® treatment in their lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**