Nevada Medicaid

Submit fax request to: 855-455-3303

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

Evrysdi® (risdiplam)
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 ❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Approval will be given if the following criteria are met and documented (chart notes, laboratory values, etc.):

- ❑ The recipient has a diagnosis of Spinal Muscular Atrophy (SMA) type I, II or III.
- ❑ Recipient has a mutation or deletion of genes in chromosome 5q resulting from one of the following: homozygous gene deletion or mutation OR compound heterozygous mutation and recipient has at least two copies of SMN 2.
- ❑ Recipient is not dependent on invasive ventilation or tracheostomy and non-invasive ventilation beyond use for naps and nighttime sleep.
- ❑ Recipient has had at least one of the following exams (based on recipient's age and motor ability): Hammersmith Infant Neurological Exam or Hammersmith Functional Motor Scale or Upper Limb Module Test or Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders or Motor Function Measure 32 Scale. (NOTE: Baseline assessments for recipients less than two months of age requesting risdiplam proactively are not necessary as to not delay access to initial therapy in recently diagnosed infants. Initial assessments shortly post-therapy can serve as baseline with respect to efficacy reauthorization assessment.)
- ❑ The medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA.
- ❑ Recipient is not to receive concomintant chronic SMN modifying therapy for the treatment of SMA (e.g., Spinraza®).
- ❑ Recipient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma®) or response has been inadequate.
- ❑ Recipient has previously received gene therapy for the treatment of SMA (e.g., Zolgesma®) and the provider attests that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of six months).

For recertification:

- ❑ The recipient has documentation of positive clinical response to therapy.
- ❑ Documentation of positive clinical response to therapy from pretreatment baseline status as demonstrated by the most recent results from one of the following exams: HINE-2, HFMSE, ULM, CHOP INTEND, MFM-32.
- ❑ Recipient remains not dependent on invasive ventilation or tracheostomy and use of non-invasive ventilation beyond use for naps and nighttime sleep.
- ❑ The medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA.
- ❑ Recipient is not to receive concomitant chronic SMN modifying therapy for the treatment of SMA (e.g., Spinraza®).
- ❑ Recipient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma®).
- ❑ Recipient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma®) and the provider attests that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of six months).

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

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.