OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Evrysdi™ (Risdiplam) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____) ***Start Date (or date of next dose):*** _____

Member's Weight: _____ ***Date Taken:*** _____ ***Dose:*** _____ **Regimen:** _____

Billing Provider Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Will Evrysdi™ be constituted to an oral solution by a pharmacist prior to dispensing? Yes☐ No☐

Will Evrysdi™ be shipped via cold chain supply to adhere to the storage and handling requirements? Yes☐ No☐

Pharmacist signature *(required)*: _____ **Date:** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

***Page 1 of 2—Please complete and return all pages. Failure to complete <u>all</u> pages will result in processing delays.**

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. What is the member's diagnosis?
   - ❑ Spinal Muscular Atrophy (SMA)
     - A. What type of SMA does the member have (0-4)?_____
     - B. Does member currently have symptoms consistent with SMA? Yes☐ No☐
     - C. Has the diagnosis been confirmed by molecular genetic testing? Yes☐ No☐
     - D. Does member have biallelic pathogenic variants in the survival motor neuron gene 1 (*SMN1*)? Yes☐ No☐
   - ❑ Other:_____
2. Is member currently dependent on permanent ventilation? Yes☐ No☐
   - A. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support:_____
3. Is Evrysdi™ being prescribed by a neurologist, specialist with expertise in the treatment of SMA, or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA? Yes☐ No☐
4. Does prescriber agree to monitor member's liver function prior to initiating Evrysdi™ and periodically while member is receiving Evrysdi™ treatment? Yes☐ No☐
5. Has the member or caregiver been instructed on the proper storage of Evrysdi™ and how to prepare the prescribed daily dose of Evrysdi™ prior to administration of the first dose? Yes☐ No☐
6. For female members of reproductive potential, please answer <u>all</u> of the following:
   - A. Is the member pregnant? Yes☐ No☐
   - B. Does the member have a negative pregnancy test prior to initiation of Evrysdi™ treatment? Yes☐ No☐
   - C. Is the member willing to use effective contraception during treatment with Evrysdi™ and for at least 1 month after the last dose? Yes☐ No☐
7. For male members of reproductive potential, has the member been counseled on the potential effects of Evrysdi™ on fertility and is the potential of compromised male fertility acceptable? Yes☐ No☐
8. Has member previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi)? Yes☐ No☐
9. Has the member previously been treated with Spinraza® (nusinersen)? Yes☐ No☐
   - A. If yes, will the member discontinue treatment with Spinraza® upon approval of Evrysdi™? Yes☐ No☐
10. Has a baseline assessment been performed and documented using a functionally appropriate exam [e.g., Hammersmith Infant Neurological Exam (HINE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Upper Limb Module (ULM) Test, or Hammersmith Functional Motor Scale Expanded (HFMSE)]? Yes☐ No☐
    - A. If yes, please indicate the exam performed:_____
    - B. Please provide member's baseline score to exam listed above:_____

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

<u>CONFIDENTIALITY NOTICE</u>

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***Page 2 of 2—Please complete and return all pages. Failure to complete <u>all</u> pages will result in processing delays.**

For Continued Authorization:

1. Has the member previously been approved through the SoonerCare prior authorization process? Yes☐ No☐
   A. If no, please complete the initial authorization section above.
2. Is member responding to the medication as demonstrated by a clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment? Yes☐ No☐
3. Please indicate exam used to perform assessment: _____
   A. Please provide member's baseline score to exam listed above: _____
   B. Please provide member's current score to exam listed above: _____
4. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: _____

Additional Information: _____
_____

Please complete and return all pages. Failure to complete <u>all</u> pages will result in processing delays.

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>

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