

**Zolgensma® (onasemnogene abeparvovec-xioi) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Physician billing (HCPCS code:** \_\_\_\_\_ **)**  **Pharmacy billing (NDC:** \_\_\_\_\_ **)**

The NDC for this weight-based medication is specific to the dose required. The NDC should reflect the member's current weight.

**Projected Date of Infusion:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_

**Billing Provider Information**

**Provider NPI:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_

**Provider Phone:** \_\_\_\_\_ **Provider Fax:** \_\_\_\_\_

**Name of outpatient hospital facility where Spinraza will be delivered to and administered at:**

\_\_\_\_\_

**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 all pages will result in processing delays.**

**For Authorization: (only 1 infusion will be approved per member per lifetime)**

1. If not previously submitted, please provide the member's recent progress notes discussing respiratory status.

2. What is the member's diagnosis?

**Spinal Muscular Atrophy (SMA)**

A. Has the diagnosis been confirmed by molecular genetic testing? Yes \_\_\_ No \_\_\_

i. If yes, please submit results of genetic testing.

B. Does member have biallelic pathogenic variants in the survival motor neuron gene 1 (SMN1)?

Yes \_\_\_ No \_\_\_

**Other:** \_\_\_\_\_

3. Will member have reached full-term gestational age prior to the "Projected Date of Infusion" provided in the Drug Information section of this form? Yes \_\_\_ No \_\_\_

4. Is member currently dependent on permanent invasive ventilation? Yes \_\_\_ No \_\_\_

**If member requires ventilator support, please provide a recent nursing note stating hours on the ventilator per day.**

A. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: \_\_\_\_\_

B. If member is currently dependent on permanent ventilation, how many continuous days has member required ventilator support? \_\_\_\_\_

C. Has the member required ventilator support in the absence of an acute, reversible illness or a perioperative state? Yes \_\_\_ No \_\_\_

5. Is Zolgensma® prescribed by a neurologist or 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 \_\_\_

**(Page 1 of 2)**

**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**

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

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**Zolgensma® (onasemnogene abeparvovec-xioi) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Criteria**

**\*Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.**

**For Authorization: (continued)**

6. Please provide member's baseline anti-AAV9 antibody titers: \_\_\_\_\_
7. Does prescriber agree to monitor liver function tests and platelet counts at baseline and as directed by the Zolgensma® prescribing information? Yes \_\_\_ No \_\_\_
8. Does prescriber agree to administer systemic corticosteroids starting 1 day prior to the Zolgensma® infusion and continue as recommended in the prescribing information based on member's liver function? Yes \_\_\_ No \_\_\_
9. Will the facility where Zogensma® will be delivered to and administered at, and pharmacy if applicable, adhere to the storage and handling requirements in the Zolgensma® prescribing information? Yes \_\_\_ No \_\_\_
10. Is member currently receiving treatment with Spinraza®? Yes \_\_\_ No \_\_\_
11. Is member currently receiving treatment with Evrysdi®? Yes \_\_\_ No \_\_\_
12. Will Spinraza® or Evrysdi® treatment be used concomitantly with Zolgensma®? Yes \_\_\_ No \_\_\_
13. Please provide member's current weight: \_\_\_\_\_ Date taken: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*(Page 2 of 2)*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) **Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.***

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