carolina complete health

Pharmacy Prior Approval Request for Evrysdi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____Phone #: _____ Ext.____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other ____

Clinical Information

For initial authorization requests, please answer questions 1-4

1. Does the beneficiary have a diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA)? ☐ **Yes** ☐ **No**
2. Does the beneficiary have SMA phenotype 1, 2, 3? ☐ **Yes** ☐ **No**
3. Will the beneficiary use Evrysdi concomitantly with nusinersen (Spinraza) or onasemnogene abeparvovec-xioi (Zolgensma)? ☐ **Yes** ☐ **No**
4. Is this medication being prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**

For reauthorization, please answer questions 1-6

5. Has the beneficiary experienced any treatment related to adverse effects or unacceptable toxicity? ☐ **Yes** ☐ **No**
6. Has the beneficiary had clinically meaningful response to treatment as demonstrated by at least 1 of the following:
   - ☐ Stability or improvement in net motor function/milestones, including but not limited to the following validated scales: Hammersmith Infant Neurologic Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Bayley Scales of Infant and Toddler development Third Ed. (BSID-III), 6-minute walk test (6MWT), upper limb module (ULM), Motor Function Measure-32 (MFM-32), Revised Upper Limb Module (RULM) etc.
   - ☐ Stability or improvement in respiratory function tests [e.g. forced vital capacity (FVC), etc.]
   - ☐ Reduction in exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe
   - ☐ Stable or increased patient weight (for patients without a gastrostomy tube)
   - ☐ Slowed rate of decline in the aforementioned measures

Signature of Prescriber:_____Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/

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