carolina complete health

Pharmacy Prior Approval Request for Zolgensma

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): 4 weeks

Clinical Information

1. Is the member less than 2 years of age? Yes____ No____
2. Does the member have a diagnosis of spinal muscular atrophy (SMA), with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene? Yes____ No____ (Please attach additional documentation)
3. Does genetic testing confirm the presence of one of the following: Yes ____ No____
   (Please attach additional documentation and choose one or more of the following)
   - ☐ Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene)
   - ☐ Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7);
   - ☐ Compound heterozygous mutation in the SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]
4. Is this medication being prescribed by or in consultation with a neurologist? Yes____ No____
5. Does the member have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence, tracheostomy, non-invasive ventilation beyond the use for sleep)? Yes _____ No _____ (please attach documentation)
6. Has the member been previously treated with Zolgensma? Yes _____ No _____
7. Have documents been included for one of the following baseline scores:
   - ☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score
   - ☐ Hammersmith Infant Neurological Examination (HINE) Section 2 motor milestone score
   - ☐ Newborn Screening results indicating baby has SMA
8. Have documents been included for both of the following:
   - Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay
   - Baseline liver function test, platelet counts, and troponin-L
9. Is Zolgensma be prescribed concurrently with Spinraza? Yes _____ No _____
10. Does the member have an active viral infection? Yes ____ No____
11. Does the Total dose exceed 1.1 x 10^{14} vector genomes (vg) per kilogram (kg) body weight? Yes ____ No ____
12. Is Zolgensma being given in conjunction with pre and post infusion parenteral corticosteroids? Yes ____ No ____

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 all forms and lab work to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

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


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