AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Zolgensma

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
Length of therapy: ☒ 1 dose

Clinical Information

1. Is the beneficiary less than 2 years of age? Yes___ No___
2. Does the beneficiary 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 beneficiary 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 beneficiary been previously treated with Zolgensma? Yes___ No___
7. Have documents been included for **one** of the following baseline scores? Yes___ No___

__ 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? Yes___ No___

__ Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay
__ Baseline liver function test, platelet counts, INR and troponin-L

9. Is Zolgensma being prescribed concurrently with Spinraza? Yes___ No___
10. Does the beneficiary have an active viral infection? Yes___ No___
11. Does the Total dose exceed 1.1×10^{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 this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406