Zolgensma

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Clinical Criteria Questions:

1.What is the diagnosis?

❒ Spinal muscular atrophy (SMA), *Continue to #2*

❒ Other, *Continue to #11*

2. Does the patient have bi-allelic mutations in the survival motor neuron 1 (SMN1)?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

❒ Unknown, *Continue to #3*

3. Does the patient have deletion of both copies of the SMN1 gene?

❒ Yes, *Continue to #5*

❒ No, *Continue to #4*

4. Does the patient have compound heterozygous mutations of the SMN1 gene as defined by one of the following?

- Pathogenic variant(s) in both copies of the SMN1 gene
- Pathogenic variant in 1 copy and deletion of the second copy of the SMN1 gene

❒ Yes, *Continue to #5*

❒ No, *Continue to #5*

5. Is there documentation of a genetic test that confirms there are no more than 3 copies of the SMN2 gene? ***Action Required***: *Attach documentation of genetic test results confirming no more than 3 copies of the SMN2 gene*

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Is the patient less than 2 years of age at the time of infusion of onasemnogene abeparvovec-xioi?

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Is there documentation of baseline laboratory assessments such as AST, ALT, total bilirubin, and prothrombin time? ***Action Required***: *Attach documentation of baseline laboratory assessments such as AST, ALT, total bilirubin, and prothrombin time*

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Does the patient have advanced spinal muscular atrophy (e.g., complete paralysis of limbs, permanent ventilator dependence)?

❒ Yes, *Continue to #9*

❒ No, *Continue to #9*

9. Does the patient have baseline anti-adeno-associated virus serotype 9 (AAV9) antibody titers less than 1:50?

❒ Yes, *Continue to #10*

❒ No, *Continue to #10*

10. Is the requested medication prescribed by a neurologist with expertise in treating spinal muscular atrophy?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Is the request for repeat treatment or ante-partum use? **Note: Repeat treatment or ante-partum use of the requested medication is considered investigational**

❒ Yes, *Continue to #12*

❒ No, *Continue to #12*

12. Will the requested drug be used with nusinersen and/or risdiplam? **Note: Use of the requested medication with nusinersen and/or risdiplam is considered investigational**

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

13. Does the prescribed dose exceed 1 injection per lifetime?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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