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* ❑ *Inpatient Hospital* ❑ *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

 Zolgensma CFT – 10/2020.

Criteria Questions:

1. What is the diagnosis?
   ❑ Spinal muscular atrophy (SMA) ❑ Other _____
2. What is the ICD-10 code? _____
3. Does the patient have a genetically confirmed diagnosis of SMA type 1? ❑ Yes ❑ No
4. Does the patient have bi-allelic mutations in the survival motor neuron 1 (SMN1) gene (deletions or point mutations)? ***ACTION REQUIRED: If Yes, attach genetic testing results demonstrating bi-allelic mutations in the survival motor neuron 1 (SMN1) gene.*** ❑ Yes ❑ No ❑ Unknown
5. Does the patient have at least two copies of the survival motor neuron 2 (SMN2) gene?
   ❑ Yes ❑ No ❑ Unknown ***ACTION REQUIRED: Attach genetic testing results demonstrating the number of copies of the survival motor neuron 2 (SMN2) gene.***
6. Please select which, if any, of the following indicators of advanced spinal muscular atrophy (SMA) the patient has.
   ❑ Complete paralysis of limbs
   ❑ Invasive ventilatory support (tracheostomy)
   ❑ Respiratory assistance for 16 or more hours per day (including non-invasive respiratory support) continuously for 14 or more days in the absence of acute reversible illness (excluding perioperative ventilation)
   ❑ Other indicator(s) of advanced SMA
   ❑ Patient does not have any indicators of advanced SMA
7. Is patient's anti-adeno-associated virus 9 (AAV9) antibody titer less than or equal to 1:50 as determined by an enzyme-linked immunosorbent assay (ELISA) binding immunoassay? ❑ Yes ❑ No
8. Is the medication prescribed by or in consultation with a physician who specializes in treatment of spinal muscular atrophy? ❑ Yes ❑ No
9. Has the patient previously received Zolgensma? ❑ Yes ❑ No
10. Is the patient currently receiving therapy with nusinersen (Spinraza) or risdiplam (Evrysdi)? ❑ Yes ❑ No *If No, skip to #12*
11. Will nusinersen (Spinraza) or risdiplam (Evrysdi) be discontinued prior to administration of the requested drug?
    ❑ Yes ❑ No
12. Will the patient be less than 9 months of age at the time of administration of Zolgensma? ❑ Yes ❑ No
13. Please indicate the anticipated date of administration of Zolgensma. _____ ***(mm/dd/yy)***

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)**

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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com