Reset Form Print Form

Government of District of Columbia Department of Health Care Finance

Evrysdi (risdiplam)

Prior Authorization Request

Request Date: _____

MEMBER INFORMATION

Member Medicaid ID: _____

Date of Birth: _____

Member Last Name: _____

Member First Name: _____ Middle Initial: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____

Prescriber Fax: _____

Prescriber DEA Number: _____

Prescriber NPI Number: _____

Prescriber Specialty: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

Pharmacy NPI Number: _____

Refer to FDA www.fda.gov for prescribing details and approved indications.

PRIOR AUTHORIZATION CRITERIA

1. Does the member have a diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA) confirmed by either homozygous deletion of the SMN1 gene or dysfunctional mutation of the SMN1 gene?
   ☐ Yes ☐ No
2. Is the member at least 2 months of age?
   ☐ Yes ☐ No
3. Was the diagnosis made by a neurologist or has documentation been submitted of a diagnosis consultation with a neurologist?
   ☐ Yes ☐ No

Member's Name (Last, First): _____

4. Does the member have one of the following phenotypes: SMA type 1, **or** SMA type 2 with symptomatic disease, **or** SMA type 3 with symptomatic disease?
   ☐ Yes ☐ No
5. Does the member require invasive ventilation or tracheostomy?
   ☐ Yes ☐ No
6. Will risdiplam be used concomitantly with nusinersen (Spinraza) or onasemnogene abeparvovec-xioi (Zolgensma)?
   ☐ Yes ☐ No
7. Has the member had prior treatment with onasemnogene abeparvovec-xioi (Zolgensma)?
   ☐ Yes ☐ No
8. Does the member have baseline documentation (fax baseline documentation to 866-535-7622) of at least 1 motor function/milestone, 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), 6-minute walk test (6MWT), upper limb module (ULM)?
   ☐ Yes ☐ No

Length of authorization: 12 months

PRIOR AUTHORIZATION RENEWAL

1. Does the member continue to meet the above initial criteria?
   ☐ Yes ☐ No
2. Is the member absent from unacceptable toxicity or treatment related adverse event(s) from the drug?
   ☐ Yes ☐ No
3. Has the member experienced documented a clinically meaningful response (fax clinical response documentation to 866-535-7622) 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 Edition (BSID-III), 6-minute walk test (6MWT), Upper Limb Module (ULM); **OR**
   - Stability or improvement in respiratory function tests (e.g., forced vital capacity [FVC]); **OR**
   - Reduction in exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe; **OR**
   - Stable or increased member weight (for members without a gastrostomy tube); **OR**
   - Slowed rate of decline in the aforementioned measures.

   ☐ Yes ☐ No

Member's Name (Last, First): _____

DOSAGE AND ADMINISTRATION

Oral powder for solution: 0.75 mg/1 mL

Oral tablet: 5 mg

Refer to product labeling at www.accessdata.fda.gov/scripts/cder/daf/.

Fax completed PA request, lab test results, required and supporting documentation to 866-535-7622.

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

Prescriber's Signature: _____ **Date:** _____

Please fax this form to:
District of Columbia Pharmacy Program
Fax: 866-535-7622
Phone: 800-273-4962