Reset Form Print Form

Government of District of Columbia Department of Health Care Finance

Zolgensma (onasemnogene abeparvovec-xioi)

Request Date: _____

RECIPIENT INFORMATION

Recipient Medicaid ID: _____

Date of Birth: _____

Recipient Last Name: _____

Recipient 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

Instructions: Ensure the recipient meets all the criteria below and check applicable boxes.

☐ The recipient is less than 2 years of age.

☐ The recipient has a diagnosis of 5q spinal muscular atrophy confirmed by either bi-allelic deletion or dysfunctional point mutation of the SMN1 gene.

SUBMIT TO Comagine Health DHCF DC Medicaid:
https://comagine.org/program/dc-medicaid-um

Revision Date: 05/05/2026

Recipient's Name (Last, First): _____

☐ The recipient has SMA phenotype 1 confirmed by one or more of the following:

- 1-2 copies of the SMN2 gene; **OR**
- 3 or 4 copies of the SMN2 gene in the absence of the c.859G>C single base substitution modification in exon 7.

☐ The recipient has a baseline anti-AAV9 antibody titer of ≤ 1:50 measured by ELISA.

☐ The recipient does not have hepatic insufficiency. Baseline liver function will be assessed prior to initiating therapy and will continue to be monitored for at least 3 months after therapy.

☐ Used concomitantly with systemic corticosteroids (see dosage/administration in FDA Package Insert).

☐ The recipient does not have advanced disease (complete limb paralysis, permanent ventilation support, etc.).

☐ Will not be used in combination with other agents for SMA (e.g., nusinersen, risdiplam).

☐ No prior treatment with Zolgensma.

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Submit clinical documentation to Comagine Health DHCF DC Medicaid:
https://comagine.org/program/dc-medicaid-um

LENGTH OF AUTHORIZATION CRITERIA AND PRIOR AUTHORIZATION RENEWAL

Single-dose infusion. Not eligible for renewal.

DOSAGE AND ADMINISTRATION

1 kit based on weight chart provided in Table 3 of FDA Package Insert.

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

By signature, the prescriber confirms the above information is complete, accurate, and verifiable by recipient's records.

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