



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Spinal Muscular Atrophy

DATE OF MEDICATION REQUEST:        /        /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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## SECTION III: CLINICAL HISTORY

For authorization of Zolgensma<sup>®</sup>, answer questions 1–9.

1. Is the patient less than 2 years of age?  Yes     No
2. Does the patient have a diagnosis of spinal muscular atrophy (SMA) confirmed by bi-allelic deletion of the SMN1 gene or dysfunctional point mutation of the SMN1 gene?  Yes     No
3. Does the patient have SMA confirmed by one to four copies of the SMN2 gene?  Yes     No

Fax to Prime Therapeutics Management LLC if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.  
Phone: 1-866-675-7755  
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:  
Phone: 1-603-271-9384  
Fax: 1-603-314-8101





**New Hampshire Medicaid Fee-for-Service Program  
Prior Authorization Drug Approval Form**

Spinal Muscular Atrophy

**DATE OF MEDICATION REQUEST:**                    /                    /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY (Continued)**

- 4. Does the patient have a baseline anti-adenovirus serotype 9 (AAV9) antibody titer of 1:50 or less, measured by enzyme-linked immunosorbent assay (ELISA)?  Yes  No
- 5. Has the patient been assessed for hepatic impairment with lab values (e.g., bilirubin, prothrombin time, aspartate transaminase [AST], alanine transaminase [ALT])?  Yes  No
- 6. Does the patient have advanced disease (e.g., complete limb paralysis, permanent ventilation support)?  Yes  No
- 7. Will Zolgensma® be used concomitantly with parenteral corticosteroids?  Yes  No
- 8. Will Zolgensma® be used in combination with nusinersen or risdiplam?  Yes  No
- 9. Has the patient received prior treatment with Zolgensma®?  Yes  No

**For authorization of Evrysdi®, answer questions 10–14. For authorization of Spinraza®, answer questions 10–16.**

- 10. Does the patient have a confirmed diagnosis of SMA?  Yes  No
- 11. Has genetic testing been completed to demonstrate SMN1 homozygous gene deletion and mutation?  Yes  No
- 12. Has a baseline assessment been completed with at least one of the following?  Yes  No
  - Hammersmith Functional Motor Scale Expanded (HFMSE)
  - Hammersmith Infant Neurologic Exam (HINE)
  - 6-minute walk test (6MWT)
  - Upper limb module (ULM) score
  - Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
  - Bayley Scales of Infant and Toddler development Third Edition (BSID-III)
  - Respiratory Function tests
  - Patient weight
  - Exacerbations requiring hospitalization and/or antibiotic therapy for respiratory infection in last year
- 13. Has the patient received treatment with Zolgensma®?  Yes  No
- 14. Will the patient receive Evrysdi® and Spinraza® concurrently?  Yes  No

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PATIENT LAST NAME:

Grid for patient last name

PATIENT FIRST NAME:

Grid for patient first name

SECTION III: CLINICAL HISTORY (Continued)

15. Has quantitative spot urine protein testing at baseline been completed? Yes No

If yes to question 15, results will be required prior to each dose for continued approval.

Renewal lab work date(s):

16. Has a complete blood count at baseline been completed? Yes No

If yes to question 16, results will be required prior to each dose for continued approval.

Renewal lab work date(s):

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

For renewals (6 month initial, then yearly): Patient must demonstrate improvement or lack of progression in one of the assessments listed in question 12.

Renewal assessment results:

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.

Prescriber's Signature: Date:

Facility where infusion to be provided:

Medicaid Provider Number of Facility:

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