AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Evrysdi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

For initial authorization requests, please answer questions 1-5:

1. Is the patient 2 months of age or older? Yes___ No___
2. Does the beneficiary have a diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA)? Yes___ No___
3. Does the beneficiary have SMA phenotype 1, 2, 3? Yes___ No___
4. Will the beneficiary use Evrysdi concomitantly with nusinersen (Spinraza) or onasemnogene abeparvovec-xioi (Zolgensma)? Yes___ No___
5. Is this medication being prescribed by or in consultation with a neurologist? Yes___ No___

For reauthorization, please answer questions 1-7:

6. Has the beneficiary experienced any treatment related adverse effects or unacceptable toxicity? Yes___ No___
7. Has the beneficiary had clinically meaningful response 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 Ed. (BSID-III), 6-minute walk test (6MWT), upper limb module (ULM), etc.

___ Stability or improvement in respiratory function tests [e.g. forced vital capacity (FVC), etc.]

___ Reduction in exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe

___ Stable or increased patient weight (for patients without a gastrostomy tube)

___ Slowed rate of decline in the aforementioned measures

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406