Gateway Health℠ It's Wholecare.

Updated: 08/2021
PARP Approved: 10/2021

Prior Authorization Criteria

Spinal Muscular Atrophy (SMA) Medications

All requests for Spinal Muscular Atrophy (SMA) Medications require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Spinal Muscular Atrophy Medications include Spinraza (nusinersen), Zolgensma (onasemnogene Abeparvovec-xioi), and Evrysdi (risdiplam). New products with this classification will require the same documentation.

For all requests for Spinal Muscular Atrophy Medications, all of the following criteria must be met:

- Diagnosis of Spinal Muscular Atrophy (SMA)
- Prescribed by or in consultation with a neurologist with experience treating SMA
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Member is receiving comprehensive treatment based on standards of care for SMA
- Member has documentation of a baseline evaluation, including a standardized assessment of motor function such as one of the following:
    - Hammersmith Functional Motor Scale Expanded (HFMSE)
    - Hammersmith Infant Neurologic Exam (HINE)
    - Upper limb module (ULM) score
    - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
    - Six-minute walk test

For Spinraza (nusinersen) all of the following criteria must be met:

- Confirmation of diagnosis by submission of laboratory testing demonstrating corresponding mutations or deletions in chromosome 5q13 that lead to survival motor neuron (SMN) protein deficiency.
- Must not be used concomitantly with Evrysdi
- **Initial Duration of Approval:** 4 months
- **Reauthorization Criteria**
    - Documentation that the member is responding to the medication based on the prescriber's assessment.
    - Has documentation of an annual evaluation, including a standardized assessment of motor function, by a neurologist with experience treating SMA
- **Reauthorization Duration of Approval:** 12 months

For Evrysdi (risdiplam) all of the following criteria must be met:

- Member must be 2 months of age or older
- Must have a confirmed diagnosis of 5q-autosomal recessive SMA
- Must not be used concomitantly with Spinraza
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**

  - Documentation that the member is responding and benefitting from the medication based on the prescriber's assessment
  - Has documentation of an annual evaluation, including a standardized assessment of motor function, by a neurologist with experience treating SMA
- **Reauthorization Duration of Approval:** 12 months

For Zolgensma (onasemnogene abeparvovec-xioi) all of the following criteria must be met:

- Must be less than 2 years of age
- Documentation of genetic testing confirming bi-allelic *SMN1* deletions or pathogenic variants
- Member is not dependent on invasive ventilation or tracheostomy
- Member must have an anti-AAV9 antibody titer below or equal to 1:50
- The prescriber attests that the member's weight for dosing is confirmed within 14 days of dose administration.
- The prescriber attests that member will receive prophylactic prednisolone (or glucocorticoid equivalent) prior to and approximately 30 days following therapy
- Member must not have received this therapy previously
- **Duration of Approval:** Once per lifetime

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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SPINAL MUSCULAR ATROPHY (SMA) MEDICATIONS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Gateway ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Does the member have a confirmed diagnosis of spinal muscular atrophy (SMA)? ☐ Yes ☐ No ICD10 code:_____

Has the member had a baseline assessment of motor milestones? ☐ Yes ☐ No

Please select all that apply and submit documentation of baseline assessment:

- ☐ Hammersmith Functional Motor Scale Expanded (HFMSE)
- ☐ Hammersmith Infant Neurologic Exam (HINE)
- ☐ Upper limb module (ULM) score
- ☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- ☐ Six-minute walk test

For Spinraza:

Has the diagnosis been confirmed by genetic testing? ☐ Yes ☐ No

Will the member be using the medication concomitantly with Evrysdi? ☐ Yes ☐ No

For Evrysdi:

Is there a confirmed diagnosis of 5q-autosomal recessive SMA? ☐ Yes ☐ No

Will the member be using the medication concomitantly with Spinraza? ☐ Yes ☐ No

For Zolgensma:

Has the diagnosis of Spinal Muscular Atrophy (SMA) been confirmed by genetic testing? ☐ Yes ☐ No

Is member dependent on invasive ventilation or tracheostomy? ☐ Yes ☐ No

Does member have an anti-AAV9 antibody titer below or equal to 1:50? ☐ Yes ☐ No

Will the member's weight for dosing be confirmed within 14 days of dose administration? ☐ Yes ☐ No

Will the member receive prophylactic prednisolone (or glucocorticoid equivalent) prior to and approximately 30 days following therapy? ☐ Yes ☐ No

Has the member received Zolgensma previously? ☐ Yes ☐ No

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SPINAL MUSCULAR ATROPHY (SMA) MEDICATIONS
PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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MEMBER INFORMATION

Member Name:	DOB:	
Gateway ID:	Member weight:	Height:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Is the patient responding to the medication (i.e. clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment)? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date