Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Evrysdi 0.75 mg/mL oral solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Spinal muscular atrophy (SMA) type I, II, or III

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Does the member have documentation supporting positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the positive response to the therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Spinal muscular atrophy (SMA) type I, II, or III

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q6: Does the member have mutation or deletion of genes in chromosome 5q? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q7: Does the member have homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)? (Check only one that apply)

[ ] Yes (please specify type of gene mutation or deletion) _____
(*Required)

[ ] No

Q8: Does the member have compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])? (Check only one that apply)

[ ] Yes (please specify type of gene mutation or deletion) _____
(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q9: Has the member at least two(2) copies of SMN2? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q10: Which of the following exams (based on patient age and motor ability) has been conducted to establish member's baseline motor ability? (Check only one that apply)

[ ] Hammersmith Infant Neurological Exam (HINE) (infant to early childhood) (please provide test results)
_____(*Required)

[ ] Hammersmith Functional Motor Scale Expanded (HFMSE) (please provide test results)
_____(*Required)

[ ] Upper Limb Module (ULM) Test (Non ambulatory) (please provide test results)
_____(*Required)

[ ] Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) (please provide test results) _____(*Required)

[ ] Motor Function Measure 32 (MFM-32) Scale (please provide test results) _____(*Required)

[ ] None of the above (please provide clinical rationale for the request) _____(*Required)

Q11: Is the member at least 2 months old? (Check only one that apply)

[ ] Yes (please specify member's age) _____(*Required)

[ ] No (please specify member's age and provide clinical rationale for the request) _____(*Required)

Q12: Is member dependent on invasive ventilation or tracheostomy? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q13: Is member dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q14: Does the member have to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of Spinal muscular atrophy (SMA) (e.g., Spinraza)? (Check only one that apply)

[ ] Yes (please specify drug name(s) and the start and end date(s) of therapy (month/year) and please provide clinical rationale for the request) _____(*Required)

[ ] No

Q15: Has the member previously received gene replacement therapy for the treatment of Spinal muscular atrophy (SMA) (e.g., Zolgensma)? (Check only one that apply)

[ ] Yes

[ ] No

Q16: Has the member submitted medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy for the treatment of SMA (e.g., sustained decrease in at least one motor test score over a period of 6 months)? (Check only one that apply)

[ ] Yes (please specify type of medical record(s)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q17: Is the medication prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of Spinal muscular atrophy (SMA)? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

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Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	