

Evrysdi (risdiplam) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			☐ URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NUMBER:				
MALE FEMALE HEIG	GHT (IN/CM): WEIG	GHT (LB/KG): ALLERG	IES:	
	The state of the s	LOSURE AUTHORIZATION FORM WITH THIS REC		
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):				
		FIRST NAME.		
LAST NAME:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:	:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL I	DISPENSING INFORMATION			
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY DURATION OF THERAPY (SPE	RENEWAL CIFIC DATES):	IF RENEWAL: DATE THERAPY	Y INITIATED:	
(6)				

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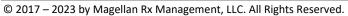


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
	10			
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.				
Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial?				
but prior to the age of 3 months? □ Yes □ No (please provide documentation) Does the patient have a confirmed diagnosis of 5q-autosomal recessive SMA? □ Yes □ No (please provide documentation)				
Does the patient have two survival motor neuron 2 (SMN2) gene copies? □ Yes □ No (please provide documentation)				
Is the patient's body weight greater th	an or equal to the third percentile for a	ge? □ Yes □ No		
Has the patient received any previous treatment of SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier, cell therapy or gene therapy (such as Zolgensma or Spinraza)? ☐ Yes ☐ No				
Does the patient require invasive vent	ilation or tracheostomy? ☐ Yes ☐ No			
SMA Type 2 or SMA Type 3 Does the patient have a confirmed diag ☐ Yes ☐ No (please provide documen	gnosis of 5q-autosomal recessive SMA? tation)			
Has the patient received any previous treatment of SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier, cell therapy or gene therapy (such as Zolgensma or Spinraza) ☐ Yes ☐ No				



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:
le the nations ambulatom 2 - Yes - No	
Is the patient ambulatory? ☐ Yes ☐ No	
Is the patient able to raise one or both hands to his/her of	own mouth? □ Yes □ No
Is the patient able to sit independently? ☐ Yes ☐ No	
Are there any other comments, diagnoses, symptoms, months physician feels is important to this review?	edications tried or failed, and/or any other information the
Please note: Not all drugs/diagnosis are covered on all pla information is received.	ns. This request may be denied unless all required
ATTESTATION: I attest the information provided is true ar the Health Plan, insurer, Medical Group or its designees m information necessary to verify the accuracy of the inform	· · · · · · · · · · · · · · · · · · ·
Prescriber Signature or Electronic I.D. Verification:	Date:
	ssion contain confidential health information that is legally privileged. If sclosure, copying, distribution, or action taken in reliance on the contents smation in error, please notify the sender immediately (via return FAX)

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811



and arrange for the return or destruction of these documents.