# 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** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK:** HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **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 DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES): | | **IF RENEWAL:** DATE THERAPY INITIATED: | |

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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:** |
|---|---|
| ☐ Spinal Muscular Atrophy (SMA)<br>☐ Other diagnosis: _____ICD-10_____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Clinical Information:**

**Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No**

**<u>SMA Type 1</u>**

**Was the patient born at a gestational age of 37 to 42 weeks, inclusive? ☐ Yes ☐ No** (please provide documentation)

**Does the patient have a clinical history, signs or symptoms attributable to Type 1 SMA with onset after age 28 days 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 than or equal to the third percentile for age? ☐ 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 ventilation or tracheostomy? ☐ Yes ☐ No**

**<u>SMA Type 2 or SMA Type 3</u>**
**Does the patient have a confirmed diagnosis of 5q-autosomal recessive SMA?**
**☐ Yes ☐ No** (please provide documentation)

**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**


Revision Date: 08/22/2018
CAT0295 11.1.2020

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Is the patient ambulatory?** □ **Yes** □ **No**

**Is the patient able to raise one or both hands to his/her own mouth?** □ **Yes** □ **No**

**Is the patient able to sit independently?** □ **Yes** □ **No**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**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 designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**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


Revision Date: 08/22/2018
CAT0295 11.1.2020