Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Spinal Muscular Atrophy

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

For authorization of Zolgensma®, answer questions 1–9.

1. Is the patient less than 2 years of age? ☐ Yes ☐ No
2. Does the patient have a diagnosis of spinal muscular atrophy (SMA) confirmed by bi-allelic deletion of the SMN1 gene or dysfunctional point mutation of the SMN1 gene? ☐ Yes ☐ No
3. Does the patient have SMA confirmed by one or more of the following? ☐ Yes ☐ No
   - Patient has 1 or 2 copies of the SMN2 gene
   - Patient has 3 copies of the SMN2 gene

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-314-8101

Review Date: 03/01/2023

Magellan Rx MANAGEMENT℠

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PATIENT LAST NAME: **PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(Continued)*

4. Does the patient have a baseline anti-AAV9 antibody titer of ≤ 1:50 measured by ELISA? ☐ Yes ☐ No
5. Has the patient been assessed for hepatic impairment with lab values (e.g., bilirubin, prothrombin time, AST, ALT)? ☐ Yes ☐ No
6. Does the patient have advanced disease (e.g., complete limb paralysis, permanent ventilation support)? ☐ Yes ☐ No
7. Will Zolgensma® be used concomitantly with parenteral corticosteroids? ☐ Yes ☐ No
8. Will Zolgensma® be used in combination with nusinersen or risdiplam? ☐ Yes ☐ No
9. Has the patient received prior treatment with Zolgensma®? ☐ Yes ☐ No

For authorization of Evrysdi®, answer questions 10–14. For authorization of Spinraza®, answer questions 10–16.

10. Does the patient have a confirmed diagnosis of spinal muscular atrophy? ☐ Yes ☐ No
11. Has genetic testing been completed to demonstrate SMN1 homozygous gene deletion and mutation? ☐ Yes ☐ No
12. Has a baseline assessment been completed with at least one of the following? ☐ Yes ☐ No
    - Hammersmith Functional Motor Scale Expanded (HFMSE)
    - Hammersmith Infant Neurologic Exam (HINE)
    - 6-minute walk test (6MWT)
    - Upper limb module (ULM) score
    - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
    - Bayley Scales of Infant and Toddler development Third Edition (BSID-III)
    - Respiratory Function tests
    - Patient weight
    - Exacerbations requiring hospitalization and/or antibiotic therapy for respiratory infection in last year
13. Has the patient received treatment with Zolgensma®? ☐ Yes ☐ No
14. Will the patient receive Evrysdi® and Spinraza® concurrently? ☐ Yes ☐ No

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SECTION III: CLINICAL HISTORY *(Continued)*

15. Has quantitative spot urine protein testing at baseline been completed? ☐ Yes ☐ No

If yes to question 15, results will be required prior to each dose for continued approval.

Renewal lab work date(s): _____

16. Has a complete blood count at baseline been completed? ☐ Yes ☐ No

If yes to question 16, results will be required prior to each dose for continued approval.

Renewal lab work date(s): _____

17. Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

For renewals (6 month initial, then yearly): Patient must demonstrate improvement or lack of progression in one of the assessments listed in question 12.

Renewal assessment results:

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.

Prescriber's Signature: _____ **Date**: _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____

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