Evrysdi™ (risdiplam) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277
For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one)*: ☐ **Neurologist** ☐ **Pediatrician** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Evrysdi (risdiplam) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

☐ Yes ☐ No Does the patient have a documented diagnosis of spinal muscular atrophy (SMA)?
→ Please confirm the type of SMA: ☐ SMA Type 1 ☐ SMA Type 2 ☐ SMA Type 3 ☐ SMN Type 4 ☐ Unknown

☐ Yes ☐ No Is the patient dependent on invasive ventilation or tracheostomy?

☐ Yes ☐ No Is the patient dependent on use of non-invasive ventilation support beyond naps and nighttime sleep?

☐ Yes ☐ No Is the medication prescribed by or in consultation with a physician who specializes in treatment of spinal muscular atrophy (SMA)?

☐ Yes ☐ No Was the patient previously established and is re-starting therapy with the requested drug after administration of gene replacement therapy for SMA (e.g., Zolgensma)?

☐ Yes ☐ No Will the requested drug be used concomitantly with Spinraza?

☐ Yes ☐ No Does the daily dose exceed the recommended dose based on patient's age and weight?

Please indicate the requested dose based on patient's age and weight: ☐ 0.2mg/kg ☐ 0.25 mg/kg ☐ 5 mg

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation of Therapy (clinical documentation required):

☐ Yes ☐ No Was the diagnosis of spinal muscular atrophy confirmed by genetic confirmation of 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote?

☐ Yes ☐ No Has a baseline assessment been completed using one of the following assessment tools (based on patient age and motor ability) to establish baseline motor ability? Date completed:____/____/____

→ ☐ Hammersmith Infant Neurological Exam Part 2 (HINE-2): Please indicate the score: _____
☐ Hammersmith Functional Motor Scale Expanded (HFMSE): Please indicate the score: _____
☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND): Please indicate the score: _____
☐ MFM32: Please indicate the score: _____
☐ Bayley Scales of Infant and Toddler Development- Third Edition (BSID-III)

☐ Yes ☐ No Has the patient previously received gene replacement therapy for spinal muscular atrophy (e.g., Zolgensma)?

→ ☐ Yes ☐ No Has the patient experienced a worsening in clinical status since receiving gene therapy as demonstrated by a decline of minimally clinical important difference from highest score achieved on one of the following exams (based on member age and motor ability)? Date completed:____/____/____

☐ Hammersmith Infant Neurological Exam Part 2 (HINE-2)
→ ☐ Yes ☐ No Has the patient experienced a decline of at least 2 points on kicking and 1 point on any other milestone (excluding voluntary grasp) from the highest score achieved on HINE-2 since receiving gene therapy? Please indicate the score: _____

☐ Hammersmith Functional Motor Scale Expanded (HFMSE)
→ ☐ Yes ☐ No Has the patient experienced a decline of at least 3 points from highest score achieved on HFMSE since receiving gene therapy? Please indicate the score: _____

☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
→ ☐ Yes ☐ No Has the patient experienced a decline of at least 4 points from highest score achieved on CHOP-INTEND since receiving gene therapy? Please indicate the score: _____

☐ Motor Function Measure 32 (MFM32)
→ ☐ Yes ☐ No Has the patient experienced a decline from baseline since receiving gene replacement therapy?

☐ Bayley Scales of Infant and Toddler Development- Third Edition (BSID-III)
→ ☐ Yes ☐ No Does the patient have the inability to sit without support for more than 5 seconds per item 22 of test since receiving gene replacement therapy?

☐ Yes ☐ No Has the patient received Spinraza previously?

→ Please indicate date of last dose: ____/____/____

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation of Therapy (clinical documentation required):

☐ Yes ☐ No Was the patient prescribed the requested drug due to clinical worsening after receiving gene replacement therapy (e.g., Zolgensma)?

☐ Yes ☐ No Has there been stabilization or improvement in clinical status with the requested drug therapy (e.g., impact on motor milestones)?

☐ Yes ☐ No Has the patient experienced a positive clinical response with the requested drug since pretreatment baseline documented by one of the following assessments? Date completed: ____/____/____

→ ☐ Hammersmith Infant Neurological Exam Part 2 (HINE-2)

→ ☐ Yes ☐ No Has the patient experienced any of the following per the most recent HINE-2 assessment (less than 1 month prior to continuation request)?

→ ☐ Patient exhibited improvement or maintenance of previous improvement of at least a 2 point (or maximal score) increase in ability to kick. Please indicate the score: ____

☐ Patient exhibited improvement or maintenance of previous improvement of at least a 1 point (or maximal score) increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, standing, or walking) excluding voluntary grasp. Please indicate the score: ____

☐ None of the above

☐ Yes ☐ No Has the patient experienced any of the following per the most recent HINE-2 assessment (less than 1 month prior to continuation request)?

→ ☐ Patient exhibited improvement or maintenance of previous improvement in more HINE-2 motor milestones than worsening (net positive improvement).

☐ Patient achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit or stand unassisted, walk)

☐ None of the above

☐ Hammersmith Functional Motor Scale Expanded (HFMSE)

→ ☐ Yes ☐ No Has the patient experienced any of the following per most the recent HFMSE assessment (less than 1 month prior to continuation request)?

→ ☐ Patient exhibited improvement or maintenance of previous improvement of at least a 3-point increase in score Please indicate the score: ____

☐ Patient achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

☐ None of the above

☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)

→ ☐ Yes ☐ No Has the patient experienced any of the following per the most recent CHOP-INTEND assessment (less than 1 month prior to continuation request)?

→ ☐ Patient exhibited improvement or maintenance of previous improvement of at least a 4-point increase in score Please indicate the score: ____

☐ Patient achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

☐ None of the above

☐ MFM32

→ ☐ Yes ☐ No Has the patient experienced an increase in their MFM32 score from baseline and that increase correlates with a clinically significant functional improvement per most recent MFM32 assessment (less than 1 month prior to continuation request)?

☐ BSID-III

→ ☐ Yes ☐ No Has the patient exhibited the ability to sit without support for at least 5 seconds after 12 months of treatment per most recent BSID-III (less than 1 month prior to continuation request)?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.