

Evrysdi® (risdiplam) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Drug Information****Pharmacy billing (NDC:** _____ **) Start Date (or date of next dose):** _____**Dose:** _____ **Regimen:** _____ **Member's Weight:** _____ **Date Taken:** _____**Pharmacy Information****Pharmacy NPI:** _____ **Pharmacy Name:** _____**Pharmacy Phone:** _____ **Pharmacy Fax:** _____**Will Evrysdi® oral solution be constituted by a pharmacist prior to dispensing? Yes** ___ **No** ___ **N/A** ___**Will Evrysdi® oral solution be shipped via cold chain supply to adhere to the storage and handling requirements in the Evrysdi® Prescribing Information? Yes** ___ **No** ___ **N/A** ___**Pharmacist signature:** _____ **Date:** _____**Prescriber Information****Prescriber NPI:** _____ **Prescriber Name:** _____**Prescriber Phone:** _____ **Prescriber Fax:** _____ **Specialty** _____**Criteria*****Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.****For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. What is the member's diagnosis?
 - Spinal Muscular Atrophy (SMA)**
 - A. Has the diagnosis been confirmed by molecular genetic testing? Yes ___ No ___
 - i. If yes, please submit results of genetic testing.
 - B. Does member have biallelic pathogenic variants in the survival motor neuron gene 1 (*SMN1*)? Yes ___ No ___
 - Other:** _____
2. Is member currently dependent on permanent ventilation (defined as ≥ 16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state)? Yes ___ No ___
3. Is Evrysdi® prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA)? Yes ___ No ___
4. Does prescriber agree to evaluate the member's liver function prior to initiating Evrysdi® and verify the member does not have severe hepatic impairment (Child-Pugh C)? Yes ___ No ___
5. Has the member or caregiver been counseled on the proper storage of Evrysdi® and how to prepare the prescribed daily dose of Evrysdi® formulations prior to administration of the first dose? Yes ___ No ___
6. For male members of reproductive potential, has the member been counseled on the potential effects of Evrysdi® on fertility, and is the potential of compromised male fertility acceptable? Yes ___ No ___

(Page 1 of 2)**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE***This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

Evrysdi[®] (risdiplam) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria*****Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.****For Initial Authorization:** *(continued)*

7. For female members of reproductive potential, please answer all of the following:
- A. Is the member pregnant? Yes ___ No ___
 - B. Does the member have a negative pregnancy test prior to initiation of Evrysdi[®] treatment?
Yes ___ No ___
 - C. Is the member willing to use effective contraception during treatment with Evrysdi[®] and for at least 1 month after the last dose? Yes ___ No ___
8. Has the member previously received treatment with Itivisma[®] or Zolgensma[®]? Yes ___ No ___
9. Is member currently being treated with Spinraza[®]? Yes ___ No ___
- A. Will Spinraza[®] be discontinued upon approval of Evrysdi[®]? Yes ___ No ___
10. Has a baseline assessment been performed and documented using a functionally appropriate exam [e.g., Hammersmith Infant Neurological Exam (HINE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Upper Limb Module (ULM) Test, or Hammersmith Functional Motor Scale Expanded (HFMSSE)]? Yes ___ No ___
- A. If yes, please indicate the exam performed: _____
 - B. Please provide member's baseline score to exam listed above: _____

For Continued Authorization:

1. Is member compliant with Evrysdi[®]? Yes ___ No ___
2. Is member responding to the medication as demonstrated by a clinically significant improvement or maintenance of function from pre-treatment baseline status using the same exam as performed at baseline assessment? Yes ___ No ___
3. Please indicate exam used to perform assessment: _____
- A. Please provide member's baseline score to exam listed above: _____
 - B. Please provide member's current score to exam listed above: _____
4. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: _____

Additional Information: _____

_____**Prescriber Signature:** _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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