

NC Medicaid and NC Health Choice **Pharmacy Prior Approval Request for** Zolgensma

Beneficiary Information

3. Beneficiary ID #:	1. Beneficiary Last Name:2. First Name:			
6. Prescribing Provider NPI #: 7. Requester Contact Information - Name: Phone #: Ext. Phone #: Ext. Drug Information 8. Drug Name: 9. Strength: 10. Quantity Per 30 Days: 11. Length of Therapy: ⊠ 1 dose Clinical Information 1. Is the Beneficiary less than 2 years of age? □ Yes □ No 2. Does the beneficiary have a diagnosis of spinal muscular atrophy (SMA), with bi-allelic mutations in the survival motor neuron (SMN1) gene? □ Yes □ No (Please attach additional documentation) 3. Does genetic testing confirm the presence of one of the following: □ Yes □ No(Please attach additional documentation) 1. Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene) □ Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7); □ Compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)] 4. Is this medication being prescribed by or in consultation with a neurologist? □ Yes □ No 5. Does the beneficiary have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence, tracheosto non-invasive ventilation beyond the use for sleep)? □ Yes □ No (please attach documentation) 6. Has the beneficiary been previously treated with Zolgensma? □ Yes □ No 7. Have documents been included for one of the following baseline scores: □ Children's Hospital of Philadelphis Infant Test of Neuromuscular Disorder (CHOP-INTEND) score □ Hammersmith Infant Neurological Examination (HINE) Section 2 motor milestone score □ Newborn Screening results indicating baby has SMA 8. Have documents been included for both of the following: • Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay • Baseline laboratory tests demonstrating Anti-AAV9 antibody titers ≤ 1:50 as determined by ELISA binding immunoassay • Baseline lever function test, platelet counts, and troponin-L 9. Is Zolgensma being prescribed concurrently with Spinraza? □ Yes □ No	3. Beneficiary ID #:	4. Beneficiary Date of Birth: _	5. Bene	eficiary Gender:
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11. Does the Total dose exceed 1.1 x 1014 vector genomes (vg) per kilogram (kg) body weight? ☐ Yes ☐ No 12. Is Zolgensma being given in conjunction with pre and post infusion parenteral corticosteroids? ☐ Yes ☐ No	(SMN1) gene? ☐ Yes ☐ No (Please 3. Does genetic testing confirm the pre choose one or more of the following ☐ Homozygous deletions of SMN1 (☐ Homozygous mutation in the SMN ☐ Compound heterozygous mutation SMN1 (allele 2)] 4. Is this medication being prescribed to the sum on the service of the beneficiary have advanced non-invasive ventilation beyond the sum on the service of the beneficiary been previously sum of the service of the se	e attach additional documentation) sence of one of the following: □ Yes □ No gene (e.g., absence of the SMN1 gene) N1 gene (e.g., biallelic mutations of exon in in the SMN1 gene [e.g., deletion of SMI by or in consultation with a neurologist? □ d SMA (e.g., complete paralysis of limbs, use for sleep)? □ Yes □ No (please atta treated with Zolgensma? □ Yes □ No one of the following baseline scores: a Infant Test of Neuromuscular Disorder of Examination (HINE) Section 2 motor mi atting baby has SMA both of the following: rating Anti-AAV9 antibody titers ≤ 1:50 as a counts, and troponin-L currently with Spinraza? □ Yes □ No e viral infection? □ Yes □ No	No(Please attach additional 7); N1 exon 7 (allele 1) and mu Yes □ No permanent ventilator dependent documentation) (CHOP-INTEND) score lestone score determined by ELISA bindi	documentation and tation of dence, tracheostomy,

(Prescriber Signature Mandatory)

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.

Pharmacy PA Call Center: (866) 246-8505