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

# Zolgensma

## Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

## Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ 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 1 (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 and choose one or more of the following)
   - ☐ 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, tracheostomy, 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 Philadelphia 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 liver function test, platelet counts, and troponin-L
9. Is Zolgensma being prescribed concurrently with Spinraza? ☐ **Yes** ☐ **No**
10. Does the beneficiary have an active viral infection? ☐ **Yes** ☐ **No**
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**

Signature of Prescriber: _____ Date: _____

**(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.

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505