

EVRYSDI (risdiplam) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Evrysdi (risdiplam)** are available on the DHS Pharmacy Services website at
<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Medication: Evrysdi 60 mg/80 mL bottle	# of bottles: _____ 60 mg/80 mL bottles	Refills:
Directions:		
Diagnosis:	Dx code (<i>required</i>):	Weight: _____ kg
Is Evrysdi prescribed by or in consultation with a neurologist with experience treating SMA?	<input type="checkbox"/> Yes <i>Submit documentation of consultation with specialist, if applicable.</i> <input type="checkbox"/> No	
Will the beneficiary be using Spinraza in addition to Evrysdi?	<input type="checkbox"/> Yes <i>Submit complete medication list.</i> <input type="checkbox"/> No	
<u>Submit documentation</u> of the beneficiary's comprehensive treatment regimen, such as nutritional support, physical therapy, respiratory care, etc.		

INITIAL Requests

Does the beneficiary have a diagnosis of spinal muscular atrophy (SMA) with the corresponding mutation or deletion in the SMN gene found at chromosome 5q13?	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of Evrysdi for the beneficiary's diagnosis.</i>	
Did the beneficiary have a <u>baseline</u> evaluation, including a standardized assessment of motor function (eg, HINE, ULM, etc.), by a neurologist with experience treating SMA?	<input type="checkbox"/> Yes <i>Submit documentation of baseline evaluation and assessment.</i> <input type="checkbox"/> No	

RENEWAL Requests

Did the beneficiary have an <u>annual</u> evaluation, including a standardized assessment of motor function (eg, HINE, ULM, etc.), by a neurologist with experience treating SMA?	<input type="checkbox"/> Yes <i>Submit documentation of annual evaluation and assessment.</i> <input type="checkbox"/> No	
Is the beneficiary experiencing clinical benefit from Evrysdi?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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