Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Evrysdi™ (risdiplam)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty (if applicable):	Prescriber Fax:	

*Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy, and attach supporting documentation.*

☐ INITIATION OF THERAPY

1. Supporting chart notes are attached (required). ☐ Yes ☐ No
2. Medication is prescribed by a neurologist. ☐ Yes ☐ No
3. Current weight: _____
4. Member must have a diagnosis of Spinal Muscle Atrophy Type 1, 2 or 3. Please document type: _____
5. Genetic test results are attached confirming chromosome 5q homozygous deletions or dysfunctional point mutations of the SMN1 gene and 2 to ≤ 4 copies of SMN 2 gene. ☐ Yes ☐ No
6. Does member require permanent ventilator dependence? ☐ Yes ☐ No
7. Documentation is included of a baseline motor function milestone evaluation using at least one of the following age-appropriate screening tools attached: HINE-2, CHOP-INTEND, HFMSE, RULM, 6MWT, BSID-III or MFM32. ☐ Yes ☐ No
8. Has member previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi)? ☐ Yes ☐ No
   Note: If yes, provide supporting documentation for need of Evrysdi™ (required).
9. Is member currently being treated with Spinraza® (nusinersen)? ☐ Yes ☐ No

LIMITATIONS: Authorization will be granted for a dose based on age and body weight per manufacturer's labeling, with a maximum dose of 5mg/day.

Initial authorization will be issued for one year.

☐ CONTINUATION OF THERAPY

1. Supporting chart notes are attached (required). ☐ Yes ☐ No
2. Member has been compliant with Evrysdi™ therapy. ☐ Yes ☐ No
3. Member is receiving a benefit from Evrysdi™ therapy, as demonstrated by improvement or maintenance of motor skills as compared to pre-treatment baseline using an age appropriate screening tool. ☐ Yes ☐ No
   (Must attach documentation of motor skill assessment. See #8 above for appropriate screening tools.)
4. Current weight: _____
5. Has member received treatment with Zolgensma® since starting Evrysdi™? ☐ Yes ☐ No
6. Has member started treatment with Spinraza® since starting Evrysdi™? ☐ Yes ☐ No

LIMITATIONS: Authorization will be granted for a dose based on age and body weight per manufacturer's labeling, with a maximum dose of 5mg/day.

Reauthorization will be issued for one year.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.