

# RISDIPLAM

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermy meds.com](http://covermy meds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Spinal Muscular Atrophy (SMA) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____ 3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist, geneticist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Will the patient be using the requested agent in combination with Spinraza (nusinersen) for the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Does the patient require invasive ventilation or tracheostomy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Does the patient have a diagnosis of Spinal Muscular Atrophy (SMA)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Has genetic testing confirmed the deletion or mutation at the survival motor neuron 1 (SMN1) gene in chromosome 5q? Please note, medical records are required. .... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit medical records. 8. Does the patient have a diagnosis of probable SMA Type 1, 2, or 3? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Is the patient symptomatic or asymptomatic? Please select one and answer the corresponding questions. <input type="checkbox"/> Symptomatic Was the patient symptom onset evident prior to 18 years of age? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asymptomatic Does the patient have more than 4 copies of SMN2? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Is the patient symptomatic or asymptomatic? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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11. Has the patient received gene therapy for the requested indication (e.g., Zolgensma [onasemnogene abeparvovec-xioi])? .....  Yes  No
12. Has the patient had at least ONE of the following baseline (prior to starting therapy with the requested agent) functional assessments based on age and motor ability:
- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
  - Hammersmith Infant Neurological Examination (HINE-2)
  - Hammersmith Functional Motor Scale-Expanded (HFMSE)
  - Six-minute walk test (6MWT)
  - Bayley Scales of Infant and Toddler Development (BSID)
  - Motor Function Measurement score (MFM32)
  - Revised Upper Limb Module (RULM) test
  - None of the above baseline functional assessments completed
13. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- For renewal requests:**
14. Has the patient had improvement or stabilization from baseline (prior to starting therapy with the requested agent) with the requested agent as indicated by one of the following functional assessments based on patient age and motor ability? Please select one.
- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
  - Hammersmith Infant Neurological Examination (HINE-2)
  - Hammersmith Functional Motor Scale-Expanded (HFMSE)
  - Six-minute walk test (6MWT)
  - Bayley Scales of Infant and Toddler Development (BSID)
  - Motor Function Measurement score (MFM32)
  - Revised Upper Limb Module (RULM) test
  - No improvement or stabilization from baseline from the above tests

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**

**BCBSIL: 800.285.9426**

**BCBSMT: 888.723.7443**

**BCBSNM: 800.544.1378**

**BCBSOK: 800.991.5643**

**BCBSTX: 800.289.1525**

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