



Risdiplam Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
03-15-2026

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Evrysdi	risdiplam for soln ; risdiplam tab	0.75 MG/ML ; 5 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Evrysdi	Risdiplam For Soln	0.75 MG/ML	3	Bottles	30	DAYS	1 bottle=80 mL		
Evrysdi	risdiplam tab	5 MG	30	Tablets	30	DAYS			

ADDITIONAL QUANTITY LIMIT INFORMATION

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
747065600021 20	Evrysdi	Risdiplam For Soln	0.75 MG/ML	1 bottle=80 mL			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Evrysdi	risdiplam for soln ; risdiplam tab	0.75 MG/ML ; 5 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Evrysdi	Risdiplam For Soln	0.75 MG/ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Evrysdi	risdiplam tab	5 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
PA	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> The patient has a diagnosis of spinal muscular atrophy (SMA) AND The patient has a deletion or mutation at the survival motor neuron 1 (SMN1) gene on chromosome 5q confirmed by genetic testing (medical records required) AND The patient has a diagnosis of probable SMA Type 1, 2, or 3 AND ONE of the following: <ol style="list-style-type: none"> If symptomatic, symptom onset was evident prior to 18 years of age OR If asymptomatic, the patient has no more than 4 copies of SMN2 AND The patient has had at least ONE of the following baseline (prior to starting therapy with the requested agent) functional assessments based on patient age and motor ability:

Module	Clinical Criteria for Approval
	<p>A. Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) OR</p> <p>B. Hammersmith Infant Neurological Examination (HINE-2) OR</p> <p>C. Hammersmith Functional Motor Scale-Expanded (HFMSE) OR</p> <p>D. Six-minute walk test (6MWT) OR</p> <p>E. Bayley Scales of Infant and Toddler Development (BSID) OR</p> <p>F. Motor Function Measurement score (MFM32) OR</p> <p>G. Revised Upper Limb Module (RULM) test AND</p> <p>5. The patient does NOT require invasive ventilation or tracheostomy AND</p> <p>6. The patient has NOT received gene therapy (e.g., Zolgensma [onasemnogene abeparvovec-xioi]) for the requested indication AND</p> <p>7. If the patient has used Spinraza (nusinersen) in the last four months, then they will complete a four-month washout period between the last Spinraza (nusinersen) dose and the initiation of therapy with the requested agent AND</p> <p>8. The patient will NOT be using the requested agent in combination with Spinraza (nusinersen) for the requested indication AND</p> <p>9. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., neurologist, geneticist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis AND</p> <p>10. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p>

Module	Clinical Criteria for Approval
	<p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. The patient has 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: <ol style="list-style-type: none"> A. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) OR B. Hammersmith Infant Neurological Examination (HINE-2) OR C. Hammersmith Functional Motor Scale-Expanded (HFMSE) OR D. Six-minute walk test (6MWT) OR E. Bayley Scales of Infant and Toddler Development (BSID) OR F. Motor Function Measurement score (MFM32) OR G. Revised Upper Limb Module (RULM) test AND 3. The patient does NOT require invasive ventilation or tracheostomy AND 4. The patient has NOT received gene therapy (e.g., Zolgensma [onasemnogene abeparvovec-xioi]) for the requested indication AND 5. The patient will NOT be using the requested agent in combination with Spinraza (nusinersen) for the requested indication AND 6. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, geneticist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 7. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. ALL of the following: <ol style="list-style-type: none"> A. The requested quantity (dose) exceeds the program quantity limit AND B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND C. There is support for therapy with a higher dose for the requested indication OR 3. ALL of the following: <ol style="list-style-type: none"> A. The requested quantity (dose) exceeds the program quantity limit AND B. The requested quantity (dose) does NOT have a maximum FDA labeled dose for the requested indication AND

Module	Clinical Criteria for Approval
	<p data-bbox="375 180 1409 268">C. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR</p> <p data-bbox="277 268 574 300">4. ALL of the following:</p> <p data-bbox="375 300 1289 331">A. The requested quantity (dose) exceeds the program quantity limit AND</p> <p data-bbox="375 331 1377 386">B. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND</p> <p data-bbox="375 386 1333 417">C. There is support for therapy with a higher dose for the requested indication</p> <p data-bbox="232 449 646 480">Length of Approval: 12 months</p>