OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Zolgensma® (Onasemnogene Abeparvovec-xioi) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

❑ Physician billing (HCPCS code: _____) ❑ Pharmacy billing* (NDC: _____)

*The NDC for this weight-based medication is specific to the dose required. The NDC provided should reflect the member's current weight.

Projected Date of Infusion: _____ ***Dose:*** _____ ***Regimen:*** _____

Zolgensma® Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Name of outpatient health care facility where Zolgensma® will be delivered to and administered at:

_____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Authorization (Only one Zolgensma® infusion will be approved per member per lifetime):

1. If not previously submitted, please provide the **member's recent progress notes discussing respiratory status**.
2. What is the diagnosis for which the medication is being prescribed?
   - ❑ Spinal muscular atrophy (SMA)
     - A. Has the diagnosis been confirmed by molecular genetic testing? Yes ☐ No ☐
     - B. Does member have bi-allelic pathogenic variants in the *survival motor neuron gene 1* (*SMN1*)? Yes ☐ No ☐
   - ❑ Other, please list: _____
3. Will member have reached full-term gestational age prior to the "Projected Date of Infusion" provided in the Drug Information section of this form? Yes ☐ No ☐
4. Is member currently dependent on permanent invasive ventilation? Yes ☐ No ☐
   If member requires ventilator support, please provide a recent nursing note stating hours on the ventilator per day.
   - A. If member is currently dependent on permanent ventilation, please specify number of hours per day member requires ventilator support: _____
   - B. If member is currently dependent on permanent ventilation, how many continuous days has member required ventilator support: _____
   - C. Has the member required ventilator support in the absence of an acute, reversible illness or a perioperative state? Yes ☐ No ☐
5. Is Zolgensma® being prescribed by a neurologist, specialist with expertise in treatment of SMA, or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in treatment of SMA? Yes ☐ No ☐
6. Please provide member's baseline anti-AAV9 antibody titers: _____
7. Does prescriber agree to monitor liver function tests, platelet counts, and troponin-I at baseline and as directed by the Zolgensma® prescribing information? Yes ☐ No ☐
8. Does prescriber agree to administer systemic corticosteroids starting 1 day prior to the Zolgensma® infusion and continue as recommended in the prescribing information based on member's liver function? Yes ☐ No ☐
9. Will the facility where Zolgensma® will be delivered to and administered at, and pharmacy if applicable, adhere to the storage and handling requirements in the Zolgensma® prescribing information? Yes ☐ No ☐
10. Is member currently receiving treatment with Spinraza® (nusinersen)? Yes ☐ No ☐
11. Is member currently receiving treatment with Evrysdi™ (risdiplam)? Yes ☐ No ☐
12. Will Spinraza® or Evrysdi™ treatment be used concomitantly with Zolgensma®? Yes ☐ No ☐
13. Please provide member's current weight: _____ Date taken: _____

Prescriber Signature: _____ **Date:** _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) ***Specific information/ documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.***

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*