South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

ZOLGENSMA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Dose & Frequency:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA	
☐	**Medical records to support use of product are submitted**
Initial Therapy (check one)	**Yes** ☐ **No** ☐
☐	Therapy is prescribed by a board-certified pediatric neurologist with expertise in the treatment of SMA
☐	Individual has an SMA diagnosis with submitted documentation (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in **one** of the following: ☐ Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13) ☐ Compound heterozygous mutation of SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
☐	Individual has ≤3 copies of the SMN2 gene
☐	Individual is <2 years of age
☐	For use in a neonatal patient born prematurely, the full-term gestational age has been reached
☐	Individual is not dependent on **either** of the following: • Invasive ventilation or tracheostomy • Use of non-invasive ventilation beyond use for naps and nighttime sleep
☐	Individual is not to receive routine concomitant SMN modifying therapy [e.g., Spinraza (nusinersen), Evrysdi (risdiplam)]. Patient's medical record will be reviewed and any current authorizations for SMN modifying therapy will be terminated upon Zolgensma approval; patient access to subsequent SMN modifying therapy will be assessed according to respective coverage policy of concomitant agent.
☐	Individual does not have an elevated anti-adeno-associated virus serotype 9 (anti-AAV9) antibody titer above 1:50
☐	Individual has LFTs less than 2X ULN determined by a certified lab
☐	Baseline functional status is documented by **one** of the following: ☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder score (CHOP INTEND) ☐ Hammersmith Infant Neurological Exam (HINE) ☐ Hammersmith Functional Motor Scale Expanded (HFMSE)
☐	Individual has never received Zolgensma treatment in their lifetime
PHYSICIAN SIGNATURE – PROVIDER ONLY	
This form must be signed by a neurologist	
☐	I certify that the information given in this form is a true and accurate medical indication for the required product
Name & Title (Printed):	**Specialty:**
Signature:	