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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:		HCCP Code:
Drug Name:		Quantity:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small><i>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.</i></small>		
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	
	Documentation is provided (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in one of the following: <ul style="list-style-type: none"> • 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 meets one of the following in regard to diagnosis of SMA: <ul style="list-style-type: none"> • Diagnosis of SMA by a board-certified pediatric neurologist with expertise in the diagnosis of SMA • Diagnosis of SMA based on the results of SMA newborn screening and submission of medical records (e.g., chart notes, laboratory values) confirming that patient has 3 copies or less of 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: <ul style="list-style-type: none"> • 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)]. 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-adenovirus serotype 9 (anti-AAV9) antibody titer above 1:50	
	Individual has LFTs less than 2X ULN determined by a certified lab	
	Provider attests that the patient, while under the care of the physician, will be assessed on the Hammersmith Functional Motor Scale Expanded (HFMSE) assessment (or the initial test used to establish baseline motor ability unless that test is no longer appropriate for the patient) during subsequent office visits while the patient is 2 to 3 years of age or older following exam scales during subsequent office visits	
	Individual has never received Zolgensma treatment in their lifetime	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> 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:		