HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
EVRYSDI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Evrysdi™ (risdiplam)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the therapy prescribed by, or in consultation with, a neurologist with expertise in spinal muscular atrophy?	☐	☐	
2. Does the member have a confirmed diagnosis of spinal muscular atrophy (SMA) by molecular genetic testing of 5q SMA with one of the following: • 5q SMA homozygous gene deletion • 5q SMA homozygous gene mutation • Compound heterozygote mutation (e.g. deletion of SMN1 exon 7 and mutation of SMN1)?	☐	☐	Please provide documentation
3. Does documentation show the member has a diagnosis of SMA types 1, 2, or 3?	☐	☐	Please provide documentation
4. Is the member ≤ 25 years of age?	☐	☐	
5. Is the member dependent on any of the following: • Invasive ventilation or tracheostomy • Non-invasive ventilation support beyond naps and nighttime sleep?	☐	☐	Please provide documentation
6. Does the provider attest the member is not currently pregnant and has been counseled to use effective contraception during treatment and until 1 month after the last Evrysdi™ dose?	☐	☐	
7. Does the member have hepatic dysfunction?	☐	☐	
8. Has the member received Zolgensma®?	☐	☐	

9. Is the member currently taking Spinraza® or will Spinraza® be started in addition to Evrysdi™?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member responded to initial therapy as shown by maintenance, improvement, or decreased decline in motor function?	☐	☐	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-117
Origination Date: 07/01/2024
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
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