HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
ZOLGENSMA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

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

If you have medical pharmacy prior authorization questions, please call for assistance: 833-404-4300

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:		HCPCS Code:

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: ☐ Zolgensma® (onasemnogene abeparvovec-xioi)

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
1. Does the member have a genetically confirmed diagnosis of spinal muscular atrophy (SMA) with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene and ≤ 3 copies of SMN2?	☐	☐	**Please provide documentation**
2. Is the medication prescribed by or in consultation with a physician who specializes in the treatment of SMA?	☐	☐	**Please provide documentation**
3. Will the member be less than 2 years of age at the time of administration?	☐	☐	**Please provide documentation**
4. Is the member's weight ≤13.5 kg?	☐	☐	**Please provide documentation**
5. Does the member have advanced SMA with any of the following: • Complete paralysis of limbs • Invasive ventilator support (tracheostomy)	☐	☐	**Please provide documentation**
6. Does documentation provide anti-AAV9 antibody titer ≤1:50 as determined by Enzyme-linked Immunosorbent Assay (ELISA) Binding immunoassay?	☐	☐	**Please provide documentation**
7. Was the member born prematurely?	☐	☐	**Please provide documentation**
8. Has the member received Zolgensma® before?	☐	☐	**Please provide documentation**
9. Is the member currently receiving routine concomitant SMN modifying therapy, e.g., Spinraza® (nusinersen), Evrysdi® (risdiplam)?	☐	☐	**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-M012
Origination Date: 07/01/2024
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024