

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM
PHYSICIAN ADMINISTERED DRUG ZOLGENSMA® (onasemnogene abeparvovec-xioi)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION

Drug Name/Form: Zolgensma (onasemnogene abeparvovec-xioi)

Strength: _____

Dosing Frequency: ONCE

Length of Therapy: ONCE

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

For approval, complete the following section to receive 1 dose per lifetime – may not be renewed:

1. Prescription is by a Pediatric Neuromuscular Neurologist with expertise in SMA; **AND**
 Yes No

2. Individual has a diagnosis of 5q spinal muscular atrophy confirmed by either bi-allelic deletion or dysfunctional point mutation of the SMN1 gene, with 4 or fewer copies of SMN2; **AND**
 Yes No

3. Individual is less than 24 months of age; **AND**
 Yes No

4. Individual is not ventilator-dependent, defined as requiring invasive ventilation (tracheostomy) or respiratory assistance for 16 or more hours per day (including noninvasive ventilator support) continuously for 21 or more days in the absence of an acute reversible event; **AND**
 Yes No

5. Individual has baseline anti-AAV9 antibody titer of ≤ 1:50 measured by ELISA; **AND**
 Yes No

6. Individual has LFTs less than 2X the upper limit of normal determined by certified laboratory; **AND**
 Yes No

7. Individual has received **NO** treatment with immunosuppressive therapy in the 3 months prior to starting Zolgensma treatment (e.g., corticosteroids, cyclosporine, tacrolimus, methotrexate, cyclophosphamide, intravenous immunoglobulin, rituximab); **AND**
 Yes No

8. Individual does **NOT** have advanced disease (e.g., complete limb paralysis, permanent ventilation support); **AND**
 Yes No

9. Individual does **NOT** have symptoms of active viral infection; **AND**
 Yes No

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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10. Individual does **NOT** have concomitant illness that may create unnecessary risks for gene transfer; **AND**

Yes No

11. Individual has had **NO** prior treatment with Zolgensma.

Yes No

12. The member will NOT receive the requested treatment in combination with Spinraza (nusinersen) or Evrysdi (risdiplam)

Yes No

ADDITIONAL INFORMATION:

13. Is this for pre-symptomatic treatment?

Yes No

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.