



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Evrysdi - Non-PDL**

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is this a renewal request? If YES, go to 8. If NO, go to 2.

Yes

No

Q2. Is the medication prescribed by or in consultation with a neurologist or physician who specializes in treatment of spinal muscular atrophy?

Yes

No

Q3. Does the member have a diagnosis of spinal muscular atrophy type I, II, or III?

Yes

No

Q4. Is the patient's diagnosis of spinal muscular atrophy confirmed by the following?

. Laboratory documentation of homozygous deletion or mutation of SMN 1 gene

Yes

No

Q5. Does the prescribed dose follow the recommended dosing per Evrysdi (risdiplam) prescribing information as described below?

Oral Solution:

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<ul style="list-style-type: none"> <li>. If under 2 months of age, dose does not exceed 0.15 mg/kg per day</li> <li>. If 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day</li> <li>. If 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day</li> <li>. If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day</li> </ul> <p>5 MG Tablet:</p> <ul style="list-style-type: none"> <li>. If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day</li> </ul> <p style="text-align: center;"> <input type="checkbox"/> Yes         <span style="margin-left: 200px;"><input type="checkbox"/> No</span> </p>
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<p><b>Q6. Does the patient meet at least one of the following criteria?</b></p> <ul style="list-style-type: none"> <li>. Member is not concurrently being treated with gene therapy, including Spinraza and/or Zolgensma, or currently enrolled in a clinical trial to receive gene therapy for SMA</li> <li>. Member previously received gene therapy and was unable to maintain beneficial response in SMA-associated symptoms as documented by chart notes</li> </ul> <p style="text-align: center;"> <input type="checkbox"/> Yes         <span style="margin-left: 200px;"><input type="checkbox"/> No</span> </p>
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<p><b>Q7. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes         <span style="margin-left: 200px;"><input type="checkbox"/> No</span> </p>
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<p><b>Q8. Is the medication prescribed by or in consultation with a neurologist or physician who specializes in treatment of spinal muscular atrophy?</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes         <span style="margin-left: 200px;"><input type="checkbox"/> No</span> </p>
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<p><b>Q9. Does the patient continue to meet the diagnostic criteria?</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes         <span style="margin-left: 200px;"><input type="checkbox"/> No</span> </p>
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<p><b>Q10. Is the patient receiving clinical benefit based on the prescriber's assessment?</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes         <span style="margin-left: 200px;"><input type="checkbox"/> No</span> </p>
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Q11. Does the patient receive comprehensive treatment based on standards of care for spinal muscular dystrophy?

Yes

No

Q12. Does the prescribed dose follow the recommended dosing per Evrysdi (risdiplam) prescribing information as described below?

Oral Solution:

- . If under 2 months of age, dose does not exceed 0.15 mg/kg per day
- . If 2 months of age to less than 2 years of age, dose does not exceed 0.2 mg/kg per day
- . If 2 years of age and older, weighing less than 20 kg, dose does not exceed 0.25 mg/kg per day
- . If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

5 MG Tablet:

- . If 2 years of age and older, weighing 20 kg or more, dose does not exceed 5 mg per day

Yes

No

Q13. Does the patient have the absence of unacceptable toxicity which precludes safe administration of the drug?

Yes

No

Q14. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06