Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Spinal Muscular Atrophy (SMA) Therapy ~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing provider:
Name:___________________________________
Physician NPI: ______________________________
Specialty:__________________________________
Phone#:____________________________________
Fax#:______________________________________
Address:___________________________________
Contact Person at Office: ___________________

Member:
Name:____
Medicaid ID#: ____
Date of Birth:____________________________Sex:______________
Patient's Phone: ____
Pharmacy Name____
Pharmacy NPI: ____
Pharmacy Phone:_______________Pharmacy Fax: _____________

The following MUST be completed for MEDICAL BENEFIT requests:

HCPCS J-code(s)________________________________, CPT code(s): ____________________________

Administering Provider/Facility: Name____________________________NPI#___________________ Medicaid ID#________________

Contact person at facility: _____________________ Phone # ______________________ Fax number: _________________________

- Will this require an inpatient stay? Yes ☐ No ☐
  - If yes: Date of admission (if known) ________________ Date of procedure (if known) _________________
  - Expected length of inpatient stay: ________________________

1. Drug Requested:
   ☐ Evrysdi® (risdiplam)
   ☐ Spinraza® (nusinersen)
   ☐ Zolgensma® (onasemnogene abeparvovec-xioi)

   Strength/Route/Frequency:____ Length of Therapy:____________________
   Patient Weight (kg):____

2. Diagnosis for use of this medication (results of genetic testing must be submitted):
   ☐ SMA Type 0 ☐ SMA Type 1 ☐ SMA Type 2 ☐ SMA Type 3 ☐ SMA Type 4

3. Baseline motor ability has been established using one of the following exams (results must be submitted):
   - Hammersmith Infant Neurological Exam (HINE)
   - Hammersmith Functional Motor Scale Expanded (HFMSE)
   - Upper Limb Module Test (non-ambulatory)
   - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

4. Is there a need for invasive or non-invasive ventilation? Yes ☐ No ☐ N/A ☐
   If Yes, duration per 24 hour period:____

5. Was patient seen by any other provider for this condition? YES/ NO What specialty? _____________________________

6. Have the following laboratory tests been conducted (results must be submitted)?

   - Activated Partial Thromboplastin Time (aPTT) Yes ☐ No ☐ N/A ☐
   - Baseline anti-AAV9 antibodies Yes ☐ No ☐ N/A ☐
   - Liver Function Tests (AST, ALT, total bilirubin) Yes ☐ No ☐ N/A ☐
   - Negative Pregnancy Test Yes ☐ No ☐ N/A ☐
   - Quantitative Spot Urine Protein Yes ☐ No ☐ N/A ☐
   - Platelet Count Yes ☐ No ☐ N/A ☐
   - Prothrombin Time (PT) Yes ☐ No ☐ N/A ☐
   - Troponin-I Yes ☐ No ☐ N/A ☐

7. Other Information/ Comments: ____
   ____

Transportation information can be found at: https://dvha.vermont.gov/providers/non-emergency-medical-transportation

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentationsor concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

Prescribers Signature: ____ Date: _________________