aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/florida/providers/provider-pharmacy

Zolgensma
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information		
Medication request is NOT for an FDA approved or compendia-supported diagnosis (circle one): Yes No	Diagnosis:	ICD-10 Code:

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

What medication(s) has the member tried and failed for this diagnosis? Please specify below.

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information		
Diagnosis of Spinal Muscular Atrophy is based on gene mutation analysis AND includes the following:	☐ Bi-allelic SMNI mutations (deletion or point mutations) in the survival motor neuron 1 Gene	☐ Anti-AAV9 antibody titers of ≤ 1:50, measured by ELISA binding immunoassay

Has member reached full gestational age?	☐ Yes	☐ No	Does member have advanced SMA (complete paralysis of limbs, permanent ventilator dependence)?	☐ Yes	☐ No

Documentation presented of the following baseline laboratory tests:	☐ Platelet count within normal limits ☐ Troponin-1 within normal limits ☐ Alanine aminotransferase/ Aspartate aminotransferase (< 2x upper limit of normal) ☐ Total bilirubin within normal limits ☐ Prothrombin time within normal limits ☐ International Normalized Ratio (INR) within normal limits
Continuation of monitoring will be for at least 3 months post infusion for the following:	☐ Liver function tests ☐ Platelet counts ☐ Troponin-1
Documentation of baseline motor ability for ONE of the following:	☐ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder score (CHOP INTEND) ☐ Hammersmith Infant Neurological Exam (HINE) (infant to early childhood) ☐ Hammersmith Functional Motor Scale Expanded (HFMSE) ☐ Upper Limb Module Test (ULM) (non-ambulatory)

Does member have contraindication or	☐ Yes	☐ No	Will concomitant therapy be implemented with systemic corticosteroids?	☐ Yes	☐ No

intolerance to corticosteroid therapy?			Will the concomitant therapy be equivalent to oral prednisolone (1mg/kg/day for 30 days) starting one day prior to administration of Zolgensma?		

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call to check the status of a request.
Medicaid: 800-441-5501