Evrysdi (risdiplam)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (all must be met):

- ❑ Patient is 2 months of age or older
- ❑ This medication is prescribed by or in consultation with a physician who specializes in spinal muscular atrophy (SMA) treatment.
- ❑ Patient has documented presymptomatic or symptomatic SMA type 1-3 confirmed with genetic testing
- ❑ Patient has not previously received Zolgensma.

Re-authorization Criteria:

- ❑ Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.
- ❑ Assessment of motor function development milestones using age-appropriate screening tools.

Evrysdi Authorization: Up to one (1) year
Re-authorization: Up to one (1) year

Note:

- ❖ Use appropriate HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date