Zolgensma (onasemnogene abeparvovec-xioi)

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 the following criteria must be met)*

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the treatment of spinal muscular atrophy (SMA)
- ❑ Patient has a documented diagnosis of SMA with bi-allelic mutations in the survival motor neuron 1 (SMN 1) gene AND
- ❑ Patient is less than < 2 years of age AND
- ❑ Patient is less than < 21 kg AND
- ❑ Baseline documentation prior to Zolgensma infusion of anti-AAV9 Antibody titer of < 1:50 AND
- ❑ Patient does not have advanced SMA AND
- ❑ Assessment of motor function development milestones using age appropriate screening tools
- ❑ Labatory testing and monitoring at baseline, weekly for first month, then every other week for the second and third months, until results return to baseline
  - Liver Function (clinical exam, AST, ALT, total bilirubin, prothrombin time), Creatinine, Complete Blood Count and Troponin-I
  -

Authorization: One (1) dose per lifetime

Re-authorization: None

Note:

- ❖ Use appropriate HCPCS codes 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