

<b>POLICY NAME</b>	Evrysdi (risdiplam)	<b>POLICY #</b>	2791P
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## Criteria

### Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Evrysdi will not be covered after treatment with Zolgensma because its use following Zolgensma infusion is currently in clinical trials without confirmed efficacy data and is currently considered experimental/investigational
  - Note: Patients in the clinical trials that received Zolgensma before the age of 2 years were followed up to 5 years post-treatment and did not require additional medications
  - Requests for Evrysdi in members that have previously been treated with Zolgensma will be reviewed by a Medical Director for medical necessity
- ☐ **2.2** Evrysdi will not be covered in combination with Spinraza because the concomitant use of these two drugs has not been studied and is considered experimental/investigational
  - Requests for Evrysdi in members that have previously been treated with Spinraza will be reviewed by a Medical Director for medical necessity
- ☐ **2.3** Replacement of lost, wasted, or discarded doses will not be covered. References
  - Health Alliance's standard refill threshold will apply

## Coverage Criteria

- ☐ **1.1** Diagnosis of Spinal Muscular Atrophy (SMA) types I, II, or III

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- ☐ **1.2** Documentation of 5q SMA double gene mutation, double gene deletion, or compound heterozygote

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- ☐ **1.3** Prescribed by a Geneticist (gene specialist) or provider specializing in the treatment of SMA

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- ☐ **1.4** Documented baseline motor milestone scores according to one of the following age-appropriate assessments:
  - Hammersmith Infant Neurologic Exam (HINE)
  - Modified Hammersmith Functional Motor-Scale
  - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
  - Bayley Scales of Infant and Toddler Development
  - Motor Function Measure 32 (MFM32)

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- ☐ **1.5** Chart notes from a recent specialist visit detailing member's present disease progression and respiratory function (patient does not require invasive ventilatory support)

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- ☐ **1.6** Review of chart notes documenting diagnosis and confirming that patient has met all of the requirements for treatment with Evrysdi by both a pharmacist and medical director