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| --- | --- | --- | --- |
| **Criteria Title** | Spinal Muscular Atrophy (SMA) | | |
| **Criteria Subtitle** | Evrysdi (risdiplam) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EVRYSDI | 081371 | GCNSeqNo |

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| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 2000 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of genetic testing?  If yes, please provide documentation of genetic testing. | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select | Is the medication being prescribed by or in consultation with a neurologist? | Y | 1003 |
| N | 1235 |
| 5 | 1003 |  | Select | Is the medication being concomitantly prescribed with other treatments for Spinal Muscular Atrophy (SMA) such as Zolgensma or Nusinersen? | Y | 1235 |
| N | 1004 |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of inadequate clinical response to Zolgensma (e.g., sustained decrease in CHOP-INTEND score over a 6-month period)?    If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1005 |
| 7 | 1005 |  | Select and Free Text | Has the provider submitted documentation that the patient has a contraindication to Zolgensma?  If yes, please submit the medication name and reason for inability to use. | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 2000 |  | Select and Free Text | Has the provider submitted documentation of clinical response or stabilization?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial authorizations will be up to 365 days. Subsequent authorizations will be up to 365 days.

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| **Last Approved** | 4/13/2023 |
| **Other** |  |