



**HUSKY Health Program ITVISM<sup>®</sup> (onasemnogene abeparvovec-brve)  
 Prior Authorization Request Form  
 Phone: 1.800.440.5071**

**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER  
 AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

Member Information			
Member ID #:		Member Name (Last, First):	
Address:		City, State, Zip:	
DOB:	Sex:	Weight:	Dose:
Date of Service:		Units:	
Primary Diagnosis Code:		HCPCS Code:	
Please fill out completely for all prior authorization requests.			
1. Does the individual have a diagnosis of Spinal Muscular Atrophy (SMA) which has been made by, or in consultation with, a physician with expertise in diagnosing SMA?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has the individual completed genetic testing confirming 5q SMA? <b>Please attach test results.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is the individual at least two years of age or older?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is this treatment being prescribed by, or in consultation with, a physician specializing in the management of SMA or other neuromuscular disorders? <b>If yes, please specify:</b> Provider Name: _____ Phone Number: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has the individual previously received Itvisma <sup>®</sup> or any other gene therapy for SMA? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. If the individual is currently on other SMA therapy (e.g., Spinraza <sup>®</sup> [nusinersen] or Evrysdi <sup>®</sup> [risdiplam]), will it be discontinued prior to administration of Itvisma <sup>®</sup> ? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Will the individual receive a corticosteroid regimen prior to and following receipt of Itvisma <sup>®</sup> as per the FDA-approved labeling? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Has testing for anti-AAV9 antibodies has been performed? a. If so, does the individual have an anti-AAV9 antibody titer of $\leq 1:50$ ? <b>Please attach results.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
9. Is the individual clinically stable in their overall baseline health status (e.g., hydration and nutritional status, absence of infection, respiratory status)? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is the individual up to date on all guideline-recommended vaccines? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. With regards to liver function: a. Has baseline liver function been evaluated? <b>Please attach results.</b> b. Will liver function continue to be monitored after Itvisma <sup>®</sup> infusion in accordance with the FDA-approved labeling? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
12. Has baseline creatinine and complete blood count (CBC) including hemoglobin and platelet count been obtained? <b>Please attach results.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Will CBC continue to be monitored after Itvisma <sup>®</sup> infusion in accordance with the FDA-approved labeling? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Has a description of the benefits, risks, and treatment expectations been provided to the individual and/or their parent or guardian? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Does the treating provider attest that the individual will likely benefit from therapy based on the current status of their disease? <b>Please attach provider attestation.</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Will the treating provider follow all FDA-approved labeling for dosing, administration, and monitoring for Itvisma <sup>®</sup> ?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Billing Provider Information			
Medicaid Billing Number:		Billing Provider Name:	
Street Address:		City, State, Zip:	
Contact Name:		Contact Telephone Number:	
Contact Fax Number:			
Ordering Provider Information			
Medicaid Billing Number:		Ordering Provider Name:	
Street Address:		City, State, Zip:	
Contact Name:		Contact Telephone Number:	
Contact Fax Number:		Provider Specialty:	
<b>Certification Statement:</b> This is to certify that the requested treatment is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.			
Provider Signature:			Date: