HUSKY Health Program Zolgensma® (onasemnogene abeparvovec-xioi)
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):		DOS:
DOB:	Sex:	Primary Diagnosis Code:	HCPCS Code:	
Address:		City, State, Zip:		

Please fill out completely		
1. Has the diagnosis of SMA been made by, or in consultation with, a physician with expertise in diagnosing SMA?	○Yes	○No
2. Has Zolgensma been ordered by, or in consultation, with a physician experienced in the treatment of SMA or other neuromuscular disorders?	○Yes	○No
3. Is the patient at full-term gestational age and < 2 years of age?	○Yes	○No
4. Has the patient been previously treated with Zolgensma?	○Yes	○No
5. Is the patient currently on other SMA gene-based therapy (e.g., nusinersen or risdiplam)?	○Yes	○No
6. If the patient is currently on other SMA gene-based therapy, will it be discontinued prior to administration of Zolgensma? Check here if N/A ☐	○Yes	○No
7. Has genetic testing been performed, and confirmed biallelic mutations in the *survival motor neuron (SMN1)* gene?	○Yes	○No
8. Does the patient have advanced SMA (i.e., complete paralysis of limbs, permanent ventilator dependence)?	○Yes	○No
9. Has testing for anti-AAV9 antibodies been performed, and confirmed an anti-AAV9 antibody titer of ≤ 1:50?	○Yes	○No
10. Has the patient's liver function been evaluated, and will it continue to be monitored at least 3 months post-infusion by clinical exam, and analysis of AST, ALT, total bilirubin, and PT?	○Yes	○No
11. Has testing to obtain a baseline platelet count and cardiac troponin-I been performed, and will it continue to be performed for at least 3 months post-infusion?	○Yes	○No
12. Will the administration follow the current FDA Zolgensma labeling for dosing protocol?	○Yes	○No
13. Has a description of the benefits, risks, and treatment expectations been provided to the parent or guardian?	○Yes	○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:

Certification Statement: 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: