Trillium Health Resources
Pharmacy Prior Approval Request for

Spinal Muscular Atrophy: Evrysdi

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Evrysdi** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

For initial authorization requests, please answer questions 1-5

1. Is the member 2 months of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA)? ☐ **Yes** ☐ **No**
3. Does the member have SMA phenotype 1, 2, 3? ☐ **Yes** ☐ **No**
4. Will the member use Evrysdi concomitantly with nusinersen (Spinraza) or onasemnogene abeparvovec-xioi (Zolgensma)? ☐ **Yes** ☐ **No**
5. Is this medication being prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**

For reauthorization, please answer questions 1-7

6. Has the member experienced any treatment related adverse effects or unacceptable toxicity? ☐ **Yes** ☐ **No**
7. Has the member had clinically meaningful response to treatment as demonstrated by at least 1 of the following:
   - ☐ Stability or improvement in net motor function/milestones, including but not limited to the following validated scales: Hammersmith Infant Neurologic Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Bayley Scales of Infant and Toddler development Third Ed. (BSID-III), 6-minute walk test (6MWT), upper limb module (ULM), etc.
   - ☐ Stability or improvement in respiratory function tests [e.g. forced vital capacity (FVC), etc.]
   - ☐ Reduction in exacerbations necessitating hospitalization and/or antibiotic therapy for respiratory infection in the preceding year/timeframe
   - ☐ Stable or increased member weight (for members without a gastrostomy tube)
   - ☐ Slowed rate of decline in the aforementioned measures

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277