Itvisma

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst Itvisma SGM 7318-A – 04/2026.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?
❒ Spinal muscular atrophy (SMA), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Is the medication prescribed by or in consultation with a physician who specializes in treatment of spinal muscular atrophy?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Does the patient have a genetically confirmed diagnosis of SMA?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Does the patient have bi-allelic pathogenic variants in the survival motor neuron 1 (SMN1) gene (deletions or point mutations)? ***ACTION REQUIRED***: If Yes, attach genetic testing results demonstrating bi-allelic pathogenic variants in the survival motor neuron 1 (SMN1) gene.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 5*
❒ No*, Continue to 5*
❒ Unknown*, Continue to 5*

5. Does the patient have 3 or less copies of SMN2 gene? ***ACTION REQUIRED***: If Yes, please attach laboratory assay (e.g., quantitative PCR or MLPA) identifying copies of SMN2 gene. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. At what age did the patient have onset of clinical signs and symptoms of disease?
❒ 6 months of age or older, *Continue to 7*
❒ Less than 6 months, *Continue to 7*

7. What is the patient's age at the time of treatment administration?
❒ Less than two (2) years of age, *Continue to 8*
❒ Two (2) years of age to less than eighteen (18) years, *Continue to 8*
❒ 18 years of age or older, *Continue to 8*

8. Please select which, if any, of the following ventilation support the patient requires.
❒ Invasive ventilatory support, *Continue to 9*
❒ Awake noninvasive ventilation for greater than 6 hours during a 24-hour period, *Continue to 9*
❒ Noninvasive ventilation for greater than 12 hours during a 24-hour period or require tracheostomy, *Continue to 9*
❒ Other, please explain. _____, *Continue to 9*
❒ Patient does not require any ventilation support., *Continue to 9*

9. Does the patient have contraindication(s) to lumbar puncture procedure (e.g., increased intracranial pressure, any impediment to cerebrospinal fluid access, administration of any intrathecal therapy)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is patient's anti-adeno-associated virus 9 (AAV9) antibody titer less than or equal to 1:50 as determined by an enzyme-linked immunosorbent assay (ELISA) binding immunoassay?

❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the patient have an active infectious process (e.g., viral, bacterial, or febrile illness) prior to treatment?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have a serious concomitant illness (e.g., severe liver or kidney disease, symptomatic cardiomyopathy)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have a history of allergy or hypersensitivity to treatment regimen (e.g., glucocorticoids) or its excipients?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has the patient's liver function, platelet count, troponin I level, creatinine level, neurologic evaluation, and Hammersmith Functional Motor Scale-Expanded (HFMSE) assessment been assessed at baseline and will be monitored after Itvisma administration as clinically appropriate? ***ACTION REQUIRED***: If Yes, please attach medical records (e.g., chart notes and/or laboratory reports) documenting baseline liver function, platelet count, troponin I level, creatinine level, neurologic evaluation, and Hammersmith Functional Motor Scale-Expanded (HFMSE) assessment. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Will the patient's vaccination status be up to date prior to Itvisma administration?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Has the patient previously received the requested drug, Zolgensma, or other gene therapy?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the patient currently receiving therapy with nusinersen (Spinraza) or risdiplam (Evrysdi)? If Yes, indicate the date of last dose.
❒ Yes, please specify date of last dose. _____ MM/DD/YYYY, *Continue to 18*
❒ No, *Continue to 19*

18. Will nusinersen (Spinraza) or risdiplam (Evrysdi) be discontinued prior to administration of the requested drug?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Please indicate the anticipated date of administration of the requested medication.
❒ Indicate the date of administration: _____ MM/DD/YYYY, *No Further Questions*
❒ Date unavailable, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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