BlueCross BlueShield
Federal Employee Program

EVRYSDI
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-270-4737

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the remainder of this form.

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

Evrysdi (risdiplam)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Please select dosage form and indicate quantity:

❑**Oral solution (bottles) - Will the patient need more than 7 bottles (560 mL) every 84 days? ❑Yes* ❑No**

***If YES*, please specify the requested quantity: _____ bottles every 84 days**

❑**Tablets - Will the patient need more than 84 tablets every 84 days? ❑Yes* ❑No**

***If YES*, please specify the requested quantity: _____ tablets every 84 days**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of spinal muscular atrophy (SMA)? ❑Yes ❑No

2. Has the patient previously received *gene therapy for SMA? ❑Yes ❑No
   Gene Therapy: Zolgensma (onasemnogene abeparvovec-xioi)

3. Will Evrysdi be used in combination with Spinraza (nusinersen)? ❑Yes ❑No

4. Has the patient been on Evrysdi continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Has the diagnosis been confirmed by genetic testing demonstrating bi-allelic mutation in the survival motor neuron 1 (SMN1) gene? ❑Yes* ❑No

      If YES, did the testing show deletion of both copies of the SMN1 gene? ❑Yes ❑No*

      If NO, did the testing show pathogenic variant(s) in both copies of the SMN1 gene? ❑Yes ❑No

   b. Is the patient symptomatic? ***Please select answer below:***

      ❑**Yes**: Is there documentation of a genetic testing confirming 2 to 4 copies of the SMN2 gene? ❑Yes ❑No

      ❑**No**: Is there documentation of a genetic test confirming 2 to 3 copies of the SMN2 gene? ❑Yes ❑No

   c. Is the patient permanently dependent on a ventilator? ❑Yes ❑No

   d. Has a baseline motor milestone score from **ONE** of the following assessments been obtained and documented: Hammersmith Infant Neurologic Exam (HINE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Upper Limb Module (ULM), Hammersmith Functional Motor Scale (HFMS)/Hammersmith Functional Motor Scale – Expanded (HFMSE), Motor Function Measure 32 (MFM32), or Revised Upper Limb Module (RULM)? ❑Yes ❑No

   e. Is the patient concurrently enrolled in a clinical trial for an experimental therapy for SMA? ❑Yes ❑No

   f. Is Evrysdi being prescribed by a neurologist, neuromuscular specialist, or pediatrician with expertise in treating SMA? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. Has the patient had clinically meaningful improvement or stabilization in motor milestones from baseline? ❑Yes ❑No