



**NC Medicaid and NC Health Choice  
Pharmacy Prior Approval Request for  
Zolgensma**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy:  1 dose

**Clinical Information**

1. Is the Beneficiary less than 2 years of age?  **Yes**  **No**
2. Does the beneficiary have a diagnosis of spinal muscular atrophy (SMA), with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene?  **Yes**  **No** (Please attach additional documentation)
3. Does genetic testing confirm the presence of one of the following:  **Yes**  **No** (Please attach additional documentation and choose one or more of the following)
  - Homozygous deletions of SMN1 gene (e.g., absence of the SMN1 gene)
  - Homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7);
  - Compound heterozygous mutation in the SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]
4. Is this medication being prescribed by or in consultation with a neurologist?  **Yes**  **No**
5. Does the beneficiary have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence, tracheostomy, non-invasive ventilation beyond the use for sleep)?  **Yes**  **No** (please attach documentation)
6. Has the beneficiary been previously treated with Zolgensma?  **Yes**  **No**
7. Have documents been included for one of the following baseline scores:
  - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND) score
  - Hammersmith Infant Neurological Examination (HINE) Section 2 motor milestone score
  - Newborn Screening results indicating baby has SMA
8. Have documents been included for both of the following:
  - Baseline laboratory tests demonstrating Anti-AAV9 antibody titers  $\leq$  1:50 as determined by ELISA binding immunoassay
  - Baseline liver function test, platelet counts, INR and troponin-L
9. Is Zolgensma being prescribed concurrently with Spinraza?  **Yes**  **No**
10. Does the beneficiary have an active viral infection?  **Yes**  **No**
11. Does the Total dose exceed 1.1 x 10<sup>14</sup> vector genomes (vg) per kilogram (kg) body weight?  **Yes**  **No**
12. Is Zolgensma being given in conjunction with pre and post infusion parenteral corticosteroids?  **Yes**  **No**

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 (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318