



Evrysdi™ (risdiplam) Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____/____/____
 Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

| | | | |
|--|-------------|-----------------------------------|-------------|
| First Name: | | Last Name: | |
| Address: | | City: | State: ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | Email: | |
| Current Weight: _____ lbs or _____ kgs | | Height: _____ inches or _____ cms | |

B. INSURANCE INFORMATION

| | |
|--|--|
| Aetna Member ID #: _____ | Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Group #: _____ | If yes, provide ID#: _____ Carrier Name: _____ |
| Insured: _____ | Insured: _____ |
| Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ | Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ |

C. PRESCRIBER INFORMATION

| | | | | |
|---|----------------------|--|--------|--------|
| First Name: | Last Name: | (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. | | |
| Address: | | City: | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: |
| Provider Email: | Office Contact Name: | | Phone: | |
| Specialty (Check one): <input type="checkbox"/> Neurologist <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other: _____ | | | | |

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

| | |
|---|---|
| Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ Address: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ | Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ |
|---|---|

E. PRODUCT INFORMATION

Request is for: Evrysdi (risdiplam) Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

Yes No Does the patient have a documented diagnosis of spinal muscular atrophy (SMA)?
→ Please confirm the type of SMA: SMA Type 1 SMA Type 2 SMA Type 3 SMN Type 4 Unknown

Yes No Is the patient dependent on invasive ventilation or tracheostomy?
 Yes No Is the patient dependent on use of non-invasive ventilation support beyond naps and nighttime sleep?
 Yes No Is the medication prescribed by or in consultation with a physician who specializes in treatment of spinal muscular atrophy (SMA)?
 Yes No Was the patient previously established and is re-starting therapy with Evrysdi after administration of gene therapy?
 Yes No Will the requested drug be used concomitantly with Spinraza?
 Yes No Does the daily dose exceed the recommended dose based on patient's age and weight?
Please indicate the requested dose based on patient's age and weight: 0.2mg/kg 0.25 mg/kg 5 mg

For Initiation of Therapy (clinical documentation required):

Yes No Was the diagnosis of spinal muscular atrophy confirmed by genetic confirmation of 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote?
 Yes No Has a baseline assessment been completed using one of the following assessment tools (based on patient age and motor ability) to establish baseline motor ability? Date completed: ____/____/____
→ Hammersmith Infant Neurological Exam Part 2 (HINE-2): Please indicate the score: _____
 Hammersmith Functional Motor Scale Expanded (HFMSSE): Please indicate the score: _____
 Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND): Please indicate the score: _____
 MFM32: Please indicate the score: _____

Continued on next page



Evrysdi™ (risdiplam) Medication Precertification Request

Page 2 of 3

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

| | | | |
|--------------------|-------------------|---------------|-------------|
| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|--------------------|-------------------|---------------|-------------|

G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

- Yes No Has the patient previously received gene therapy for spinal muscular atrophy?
- Yes No Has the patient experienced a worsening in clinical status since receiving gene therapy as demonstrated by a decline of minimally clinical important difference from highest score achieved on one of the following exams (based on member age and motor ability)? Date completed: ____/____/____
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
 - Yes No Has the patient experienced a decline of at least 2 points on kicking and 1 point on any other milestone (excluding voluntary grasp) from the highest score achieved on HINE-2 since receiving gene therapy? Please indicate the score: ____
 - Hammersmith Functional Motor Scale Expanded (HFMSE)
 - Yes No Has the patient experienced a decline of at least 3 points from highest score achieved on HFMSE since receiving gene therapy? Please indicate the score: ____
 - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
 - Yes No Has the patient experienced a decline of at least 4 points from highest score achieved on CHOP-INTEND since receiving gene therapy? Please indicate the score: ____
- Yes No Has the patient received Spinraza previously?
- Yes No Please indicate date of last dose: ____/____/____

For Continuation of Therapy (clinical documentation required):

- Yes No Was the patient prescribed Evrysdi due to clinical worsening after receiving gene therapy?
- Yes No Has there been stabilization or improvement in clinical status with Evrysdi therapy (e.g., impact on motor milestones)?
- Yes No Has the patient experienced a positive clinical response with Evrysdi since pretreatment baseline documented by one of the following assessments? Date completed: ____/____/____
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
 - Yes No Has the patient experienced any of the following per the most recent HINE-2 assessment (less than 1 month prior to continuation request)?
 - Patient exhibited improvement or maintenance of previous improvement of at least a 2 point (or maximal score) increase in ability to kick. Please indicate the score: ____
 - Patient exhibited improvement or maintenance of previous improvement of at least a 1 point (or maximal score) increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, standing, or walking) excluding voluntary grasp. Please indicate the score: ____
 - None of the above
 - Yes No Has the patient experienced any of the following per the most recent HINE-2 assessment (less than 1 month prior to continuation request)?
 - Patient exhibited improvement or maintenance of previous improvement in more HINE-2 motor milestones than worsening (net positive improvement).
 - Patient achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit or stand unassisted, walk)
 - None of the above
 - Hammersmith Functional Motor Scale Expanded (HFMSE)
 - Yes No Has the patient experienced any of the following per most the recent HFMSE assessment (less than 1 month prior to continuation request)?
 - Patient exhibited improvement or maintenance of previous improvement of at least a 3-point increase in score Please indicate the score: ____
 - Patient achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so
 - None of the above
 - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
 - Yes No Has the patient experienced any of the following per the most recent CHOP-INTEND assessment (less than 1 month prior to continuation request)?
 - Patient exhibited improvement or maintenance of previous improvement of at least a 4-point increase in score Please indicate the score: ____
 - Patient achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so
 - None of the above
 - MFM32
 - Yes No Has the patient experienced an increase in their MFM32 score from baseline and that increase correlates with a clinically significant functional improvement per most recent MFM32 assessment (less than 1 month prior to continuation request)?

Continued on next page



Evrysdi™ (risdiplam) Medication Precertification Request

Page 3 of 3

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

| | | | |
|--------------------|-------------------|---------------|-------------|
| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|--------------------|-------------------|---------------|-------------|

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.