Evrysdi

Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a prescription for Evrysdi must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf
Please complete this form in its entirety and provide all required documentation (if available)

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this request:** ☐ SMA Type 1 ☐ SMA Type 2 ☐ SMA Type 3
Member Weight	**Requested Dose**
Neuromuscular Clinic Contact Information:	**Date of last Visit:**

Has the member required continuous intubation for greater than 3 weeks?	☐ YES	☐ NO
Is the member receiving/has the member received treatment with Zolgensma?	☐ YES	☐ NO
Is the member symptomatic (ex. loss of reflexes, motor delay/weakness, abnormal EMG/neuromuscular ultrasound)?	☐ YES	☐ NO

Please confirm that all of the following is attached to the request, if applicable, along with any other documentation required, as stated in the PDL:

☐ Documentation of the member's current motor function from at least 2 of the approved assessments
☐ Documentation of genetic testing confirming bi-allelic deletions or mutations of SMN1 gene
☐ Documentation of genetic testing confirming the number of the member's SMN2 gene copies

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #