New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Evrysdi™ (risdiplam)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a confirmed diagnosis of spinal muscular atrophy? ☐ Yes ☐ No
2. Has genetic testing been completed to demonstrate SMN1 homozygous gene deletion and mutation? ☐ Yes ☐ No

Form continues on the next page.

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-271-8194

Effective Date: 08/13/2021

Magellan Rx MANAGEMENT℠

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(CONTINUED)*

3. Has a baseline assessment been completed with at least one of the following? ☐ Yes ☐ No
   - Hammersmith Functional Motor Scale Expanded (HFMSE)
   - Hammersmith Infant Neurologic Exam (HINE)
   - 6-minute walk test (6MWT)
   - Upper limb module (ULM) score
   - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND)
   - Bayley Scales of Infant and Toddler development Third Edition (BSID-III)
   - Respiratory Function tests
   - Patient weight
   - Exacerbations requiring hospitalization and/or antibiotic therapy for respiratory infection in last year
4. **For renewals (6 month initial, then yearly):** Patient must demonstrate improvement or lack of progression in one of the above assessments.

   Renewal assessment results:

   _____

Please provide any additional information that would help in the decision-making process. **If additional space is needed, please use a separate sheet.**

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.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Facility where infusion is to be provided: _____

Medicaid provider number of facility: _____

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