Prior Authorization Request Form

ZOLGENSMA® (onasemnogene abeparvovec-xioi)

BlueCross BlueShield Kansas

The following documentation is REQUIRED for prior authorization.
Incomplete forms will be returned for additional information.

Section 1 – Provider Information

CLEAR DATA

Prescriber First Name

Prescriber Last Name

Prescriber Address

City

State ZIP Code +4

(_____) _____-_____ Prescriber Phone Number

(_____) _____-_____ Prescriber Fax Number

Prescriber NPI

Prescriber Specialty

Clinic Name

Patient First Name MI

Patient Last Name

_____ /_____ /_____ Date of Birth

Patient ID Number

Patient Group Number

ICD-10 Diagnosis Code(s) – separate with a comma

CPT Code(s) – separate with a comma

If you want the allowable/contractual obligation for the CPT code(s), please list your charges for each code.

Section 2 – Information that should be considered with this request

Patient diagnosis:

☐ Spinal Muscular Atrophy (SMA)

☐ Other

ICD Code and Description

_____ /_____ /_____ Date of Service

Medication Requested

Strength

HCPCS Code

Dosing Schedule

Quantity Per Month

_____ /_____ /_____ Requested Start Date

_____ /_____ /_____ End Date

Place of Service

Route of Administration

Healthcare professional to administer? ☐ Yes ☐ No

Buy and bill? ☐ Yes ☐ No

Please select the site of care:

☐ 19 – Off campus outpatient hospital

☐ 22 – On campus outpatient hospital

☐ 24 – Ambulatory surgical center

☐ 13 – Assisted living facility

☐ Other _____

Will this medication be administered by ARJ Infusion Services? ☐ Yes ☐ No

What is the patient's weight? _____ kg

Is the patient currently treated with the requested agent? ☐ Yes ☐ No

Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No

Please continue on the next page.

Section 2 – Information that should be considered with this request (continued)

Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No

Are there medical records showing the patient has bi-allelic mutations in the survival motor neuron 1 (SMN1) gene as confirmed by genetic testing? **Medical records are required.** ☐ Yes ☐ No

Are there medical records showing the patient has three or fewer copies of the SMN2 gene? **Medical records are required.** ☐ Yes ☐ No

Does the patient have a baseline anti-AAV9 antibody titers ≤ 1:50? ☐ Yes ☐ No

Has the patient's pre-treatment liver function been assessed by clinical examination and laboratory testing (e.g., hepatic aminotransferases [aspartate aminotransferase (AST) and alanine aminotransferase (ALT)], total bilirubin, and prothrombin time)? ☐ Yes ☐ No

Will the patient have their liver function monitored for at least three months after infusion? ☐ Yes ☐ No

Will the patient receive systemic corticosteroids before and after Zolgensma infusion? ☐ Yes ☐ No

Has the patient previously been administered Zolgensma? ☐ Yes ☐ No

Does the patient have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence [defined as invasive ventilation (tracheostomy), or respiratory assistance for 16 or more hours per day (including noninvasive ventilatory support) continuously for 14 or more days in absence of an acute reversible illness, excluding perioperative ventilation])? ☐ Yes ☐ No

Will the patient receive the requested agent in combination with Spinraza or risdiplam? ☐ Yes ☐ No

Your signature required

_____
Preparer/Requestor

_____ / _____ / _____
Date Signed

_____
Print Name

Send this form with all necessary information to:

Blue Cross and Blue Shield of Kansas
Attention: Prior Authorization
P.O. Box 238, Topeka, KS 66601-1238
Fax: 785-290-0711
Email: csc@bcbsks.com