



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

Zolgensma®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Is the patient less than 2 years of age? Yes No
- Does the patient have a diagnosis of spinal muscular atrophy (SMA) confirmed by bi-allelic deletion of the SMN1 gene or dysfunctional point mutation of the SMN1 gene? Yes No
- Does the patient have SMA confirmed by 1 or more of the following?
 - Patient has 1 or 2 copies of the SMN2 gene
 - Patient has 3 copies of the SMN2 gene
- Does the patient have a baseline anti-AAV9 antibody titer of $\leq 1:50$ measured by ELISA? Yes No

(Form continued on next page.)

