Zolgensma® (onasemnogene abeparvovec-xioi) Medication Precertification Request

(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:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Neurologist** ☐ **Pediatrician** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Zolgensma (onasemnogene abeparvovec-xioi)
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 must be submitted with request):

☐ Yes ☐ No Has the patient received Zolgensma (onasemnogene abeparvovec-xioi) in the past?
☐ Yes ☐ No Does the patient have a genetically confirmed diagnosis of spinal muscular atrophy (SMA)?
→ ☐ Yes ☐ No Is there documentation of bi-allelic mutations in the survival motor neuron 1 (SMN1) gene?
→ Please select: ☐ SMN1 deletions ☐ SMN1 point mutations
Please enter the date genetic testing was completed: Date: ____/____/____
☐ Yes ☐ No Is the patient's anti-adeno-associated virus 9 (AAV9) antibody titer less than or equal to 1:50 as determined by enzyme-linked immunosorbent assay (ELISA) binding immunoassay?
☐ Yes ☐ No Does the patient have any of the following indicators of advanced disease?
→ ☐ The patient does not have advanced disease
→ Please select: ☐ Complete paralysis of limbs ☐ Invasive ventilatory support (tracheostomy) ☐ Respiratory assistance for 16 or more hours per day (including non-invasive respiratory support) continuously for 14 or more days in the absence of acute reversible illness (excluding perioperative ventilation)
☐ Other indicators of advanced disease-Please explain: _____
☐ Yes ☐ No Is the medication prescribed by or in consultation with a physician who specializes in treatment of SMA?
☐ Yes ☐ No Is the patient currently receiving therapy with Spinraza (nusinersen) or Evrysdi (risdiplam)? Date of last dose: ____/____/____
→ ☐ Yes ☐ No Will Spinraza (nusinersen) or Evrysdi (risdiplam) be discontinued prior to administration of Zolgensma (onasemnogeneabeparvovec-xioi)?

Continued on next page

Zolgensma (onasemnogene abeparvovec-xioi) Medication Precertification Request

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.

Please provide the name of the gene therapy designated center Zolgensma (onasemnogene abeparvovec-xioi) will be administered at:

Name: _____

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.