Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Evrysdi
(ridsiplam)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:
☐ Evrysdi 60mg/80ml (0.75mg/ml)

Directions for use: Dose: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? ☐ new start of therapy ☐ continued therapy
(if continued therapy) Has your patient had a documented beneficial response (for example, by an objective measurement and/or assessment tool)? ☐ Yes ☐ No
(if no) Please provide clinical support for continued use of Evrysdi. ____

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy** *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Diagnosis related to use:
☐ spinal muscular atrophy (SMA) ☐ Other *(please specify)*:

Clinical Information:
****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

(if SMA) Does the patient have complete paralysis of all limbs? ☐ Yes ☐ No
(if SMA) Does the patient have permanent ventilator dependence? ☐ Yes ☐ No

Did your patient undergo genetic testing?
☐ Yes (please include a copy of these results)
☐ No or Unknown

(if yes) Is there documentation confirming the diagnosis of spinal muscular atrophy with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene reported as at least ONE of the following:
1. homozygous deletion,
2. homozygous mutation, or
3. compound heterozygous mutation? ☐ Yes ☐ No

(if yes) Is there documentation confirming that the patient has two to four survival motor neuron 2 (SMN2) gene copies? ☐ Yes ☐ No

(if yes) Is there documentation confirming that patient has objective signs consistent with spinal muscular atrophy Types 1, 2, or 3? ☐ Yes ☐ No

Has this patient previously been treated with Zolgensma? ☐ Yes ☐ No

Has the patient received prior treatment with Spinraza? ☐ Yes ☐ No

(if Yes or Unknown) Besides Evrysdi, other treatment options include Spinraza. Which of the following best describes your patient's situation?

☐ The patient is NOT taking Spinraza, nor will they in the future. Evrysdi is the only drug the patient is/will be using.
☐ The patient is currently on another Spinraza, but this drug will be stopped and Evrysdi will be started.
☐ The patient is currently on Spinraza, and Evrysdi will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH Evrysdi AND Spinraza.
☐ other/unknown

Has it been confirmed that the patient is NOT currently pregnant? ☐ Yes ☐ No

(if yes) Has the patient been counseled to use effective contraception during treatment and until 1 month after the last Evrysdi dose? ☐ Yes ☐ No

Does the patient have hepatic impairment? ☐ Yes ☐ No

Is Evrysdi being prescribed by, or in consultation with, a physician who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders? ☐ Yes ☐ No

What is the patient's current weight in kilograms? ______________

What is the dosing being prescribed? __________________

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____ **Date:**______________________

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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