

Itvisma® (onasemnogene abeparvovec-brve) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

☐ **Physician billing (HCPCS code:** _____ **)** ☐ **Pharmacy billing (NDC:** _____ **)**

Projected Date of Infusion: _____ **Dose:** _____ **Regimen:** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Name of outpatient hospital facility where Itvisma® will be delivered to and administered at: _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

***Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.**

For Authorization: (only 1 infusion will be approved per member per lifetime)

1. What is the member's diagnosis?

☐ **Spinal Muscular Atrophy (SMA)**

A. Has the diagnosis been confirmed by molecular genetic testing? Yes ☐ No ☐

i. If yes, please submit results of genetic testing.

B. Does member have biallelic mutations in the survival motor neuron gene 1 (SMN1)? Yes ☐ No ☐

☐ **Other:** _____

3. Is member able to sit? Yes ☐ No ☐

4. Is member able to walk without assistance (i.e., able to walk without assistive devices)? Yes ☐ No ☐

5. Is Itvisma® prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA)? Yes ☐ No ☐

6. Please provide member's baseline anti-AAV9 antibody titers: _____

7. Does prescriber agree to monitor liver function tests and platelet counts at baseline and as directed by the package labeling? Yes ☐ No ☐

8. Does prescriber agree to administer systemic corticosteroids starting 1 day prior to the Itvisma® infusion and continue as recommended in the prescribing information based on member's liver function? Yes ☐ No ☐

9. Will the facility where Itvisma® will be delivered to and administered at, and pharmacy if applicable, adhere to the storage and handling requirements in the Itvisma® prescribing information? Yes ☐ No ☐

(Page 1 of 2)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Itvisma[®] (onasemnogene abeparvovec-brve) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria*****Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.****For Authorization: (continued)**10. Is member currently receiving treatment with Spinraza[®]? Yes ☐ No ☐11. Is member currently receiving treatment with Evrysdi[®]? Yes ☐ No ☐12. Has member previously received Zolgensma[®]? Yes ☐ No ☐13. Will Spinraza[®] or Evrysdi[®] treatment be used concomitantly with Itvisma[®]? Yes ☐ No ☐**Additional Information:** _____**(Page 2 of 2)****Prescriber Signature:** _____ **Date:** _____(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) **Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.**

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