Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form
Zolgensma® (onasemnogene abeparvovec-xioi) J3590

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Initial or Continuation request? ☐ Initial ☐ Continuation, please specify the start date of therapy: _____
2. Is the patient being treated by a neurologist or neuromuscular specialist with expertise in treating spinal muscle atrophy?
   ☐ Yes ☐ No
3. How old it this patient? Please put patient's age in months _____
4. What is the patient's diagnosis? ☐ Spinal Muscular Atrophy (SMA) ☐ Other. Please specify the diagnosis _____
5. Does the patient have genetically confirmed double-deletion of SMN 1 exon7?
   ☐ Yes ☐ No ☐ Unknown
6. Does the patient have less than or equal to three copies of the SMN2 gene?
   ☐ Yes ☐ No ☐ Unknown
7. Does this patient have advanced SMA such as complete paralysis of limbs, permanent ventilator dependence?
   ☐ Yes ☐ No
8. Does the member have antibodies against the viral vector, AAV9?
   ☐ Yes ☐ No ☐ Unknown
9. Is the patient currently receiving treatment with Spinraza®? ☐ Yes ☐ No
   Will the member be receiving daily corticosteroids starting at least 24 hours prior to therapy and continuing 30 days after Zolgensma® is given? ☐ Yes ☐ No ☐ Unknown
10. Has the patient's liver function including hepatic aminotrasferases (aspartate aminotransferase (AST) and alanine aminotransferase (ALT), total bilirubin, and prothrombin time been assessed?
    ☐ Yes, please attach recent liver function test results
    ☐ No
11. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name **Physician's Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	